DEVELOPING ADAPTIVE JUNIOR LEADERS IN THE ARMY NURSE CORPS

A thesis presented to the Faculty of the U.S. Army Command and General Staff College in partial fulfillment of the requirements for the degree

MASTER OF MILITARY ART AND SCIENCE
General Studies

by

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2012-01

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REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0188), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.**

1. REPORT DATE *(DD-MM-YYYY)*	**2. REPORT TYPE**	**3. DATES COVERED** *(From - To)*
08-06-2012	Master's Thesis	AUG 2011 – JUNE 2012

4. TITLE AND SUBTITLE

Developing Adaptive Junior Leaders in the Army Nurse Corps

5a. CONTRACT NUMBER

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

Major Christopher A. VanFosson

5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

U.S. Army Command and General Staff College
ATTN: ATZL-SWD-GD
Fort Leavenworth, KS 66027-2301

8. PERFORMING ORG REPORT NUMBER

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION / AVAILABILITY STATEMENT

Approved for Public Release; Distribution is Unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT

Senior Army leaders today struggle to develop adaptive junior leaders prepared to lead in chaotic operating environments. To overcome this challenge, the Army Nurse Corps introduced the Army Nursing Campaign Plan, which is nested in the security strategies of the United States. The Army Nursing Campaign Plan made the development of adaptive Army Nurses a strategic objective for the Corps. This thesis examines the need for adaptive leaders in the Army Nurse Corps and describes the manner in which its leaders are developed today. The author analyzes these development methods and demonstrates that they do not produce the adaptive leaders needed in the future operating environment. Synthesizing information from the literature review, the author establishes that the development of adaptive junior Army Nurses is reliant upon guided self-development, which is facilitated through regular mentoring, coaching and counseling. The author describes the Leadership Capabilities Map and proposes the Leadership Capabilities Map-based counseling tool for use in the development process, ensuring that junior Army Nurses are developed in accordance with the Army Nursing Campaign Plan. Future research must focus on implementing the tool and proving its effectiveness in developing adaptive junior Army Nurses.

15. SUBJECT TERMS

Army Nurse Corps, adaptive leader, leader development, Leadership Capabilities Map, LCM-based counseling tool

16. SECURITY CLASSIFICATION OF:			**17. LIMITATION OF ABSTRACT**	**18. NUMBER OF PAGES**	**19a. NAME OF RESPONSIBLE PERSON**
a. REPORT	**b. ABSTRACT**	**c. THIS PAGE**			**19b. PHONE NUMBER** *(include area code)*
(U)	(U)	(U)	(U)	173	

Standard Form 298 (Rev. 8-98)
Prescribed by ANSI Std. Z39.18

MASTER OF MILITARY ART AND SCIENCE

THESIS APPROVAL PAGE

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

DEVELOPING ADAPTIVE JUNIOR LEADERS IN THE ARMY NURSE CORPS, by Major Christopher A. VanFosson, 173 pages.

Senior Army leaders today struggle to develop adaptive junior leaders prepared to lead in chaotic operating environments. To overcome this challenge, the Army Nurse Corps introduced the Army Nursing Campaign Plan, which is nested in the security strategies of the United States. The Army Nursing Campaign Plan made the development of adaptive Army Nurses a strategic objective for the Corps. This thesis examines the need for adaptive leaders in the Army Nurse Corps and describes the manner in which its leaders are developed today. The author analyzes these development methods and demonstrates that they do not produce the adaptive leaders needed in the future operating environment. Synthesizing information from the literature review, the author establishes that the development of adaptive junior Army Nurses is reliant upon guided self-development, which is facilitated through regular mentoring, coaching and counseling. The author describes the Leadership Capabilities Map and proposes the Leadership Capabilities Map-based counseling tool for use in the development process, ensuring that junior Army Nurses are developed in accordance with the Army Nursing Campaign Plan. Future research must focus on implementing the tool and proving its effectiveness in developing adaptive junior Army Nurses.

ACKNOWLEDGMENTS

There are so many people to whom I am indebted but none so more than my wife, Kelly. In my eleven-year career, we have experienced six moves and two yearlong deployments. And, while this may not be a tremendous amount for some Army officers, it is quite a bit for an Army Nurse especially considering the competitive civilian job market for nurses. Kelly does an amazing job managing the challenges at home so that I can focus on doing what I love to do. I cannot repay her the debt I owe but I pray that my work serves as a testament that without her in my life, I could not be the man that I am today. I love you, Kelly.

To my four children, Tyler, Dylan, Haley, and Holly. Thank you for putting up with the long days and nights of research, writing, re-writing, and just plain boredom on your part. There were so many times that you wanted me to be involved in your day but I had to abstain so that I could finish this thesis. I love you all dearly and I hope that some day, you will understand why I had to be away on some of those clear, sunny days.

I would also like to acknowledge the help of my committee, Mr. Steven Boylan, Colonel Sara Breckenridge-Sproat, Mr. Thomas Creviston, and my Master of Military Art and Science small group instructor, Colonel William Raymond. Your guidance and reassurance made this thesis a much less painful process than I anticipated. I appreciate all of the constructive feedback and the occasional azimuth checks. But, most of all, I appreciate your positive attitudes throughout this time consuming process. Thank you all so much.

To Colonel Traci Crawford and Dr. Lori Loan, thank you for helping me get on track with this topic and acting as a sounding board so early in the process. Your guidance proved invaluable to me.

Finally, I would like to acknowledge the help of a few people who directly impacted this thesis in some way. Ms. Venita Krueger (Department of Graduate Studies), Dr. Constance Lowe (Department of Graduate Studies), Major Richard Hetherington (Department of Tactics), Mr. Stuart Lyon (Department of Joint, Interagency, and Multinational Operations), Dr. Ethan Rafuse (Department of Military History), Ms. Heather Turner (Combined Arms Research Library), Major Christine Baker (U.S. Army), Lieutenant Commander Kevin Chestnut (U.S. Navy), Mr. Matthew Wilder (National Geospatial Agency), Major Kenneth Starskov (Army of Denmark), Ms. Andrea Gastaldo (U.S. State Department), Major Jackson Sekgwama (Army of Botswana), and Ms. Susan Fowler (Combined Arms Research Library). Each of these individuals served as a sounding board for my thesis ideas in some way and their assistance was essential to my completion of this product.

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ACRONYMS

360-MSAF	U.S. Army 360-degree Multi-Source Assessment and Feedback tool
ACC	Army Competitive Category officer(s)
AMEDD	Army Medical Department
ANC	Army Nurse Corps
AOC	Area of Concentration
BOLC	Basic Officer Leadership Course (see OBLC)
CASAL	Center for Army Leadership Annual Survey of Army Leadership
CCC	Captains' Career Course
CNOIC	Clinical Nurse Officer-in-Charge
DSG	Deputy Surgeon General
ILE	Intermediate Level Education
LCM	Leadership Capabilities Map
LTHET	Long Term Health Education and Training
MMAS	Master of Military Art and Science
MTF	Medical treatment facility
OBLC	Officers Basic Leadership Course (see BOLC)
OER	Officer Evaluation Report
PCTS	Patient CaringTouch System
PES-NWI	Practice Environment Scale of the Nursing Work Index
ROTC	U.S. Army Reserve Officer Training Corps
SSC	Senior Staff College
TRADOC	U.S. Army Training and Doctrine Command
TSG	The Surgeon General (of the Army)

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CHAPTER 1

INTRODUCTION

Background

> The dynamic nature of the 21st-century security environment requires adaptations across the force. The most important adaptations will be in how we develop the next generation of leaders.
>
> — General Martin Dempsey, *Army Magazine*

This statement by General Dempsey, then the commanding general of U.S. Army Training and Doctrine Command (TRADOC), reflects an Army-wide concern that current and future Army leaders may not be prepared to meet the national security challenges of the future. Donald E. Vandergriff, a retired Army officer and educator, foreshadowed General Dempsey's sentiment when he posed the question, "how can we evolve the current way of developing leaders and Soldiers . . . that prepares them earlier to be complex problem solvers" (2008). Because leaders are integral to planning, training, and executing Army missions across the full spectrum of operations, in a variety of environments, their development is a renewed priority for senior Army leaders today. While General Dempsey and Vandergriff may have been speaking about Army leaders in broad terms, trying to outline coming changes that would change leadership development Army-wide, the Army Nurse Corps (ANC) had already moved to improve the development of its leaders.

Two years prior to General Dempsey's article, then Chief of the ANC, Major General Patricia Horoho, published the *ANC Campaign Plan* and placed the ANC on the path to leadership development reform. The plan reflects an increasing demand for Army Nurses that cannot be met during a time of persistent conflict that makes recruiting and

retention even more difficult, especially when healthcare systems nationwide are suffering from a shortage of nurses (Army Nurse Corps 2009). Believing that such efforts will improve Army Nurse recruiting and retention, as well as prepare Army Nurses to lead in a variety of environments, the Campaign Plan calls for developing leaders "who are creative thinkers, intrepid explorers, who can see beyond what is today to shape the future, who are adaptive to any conditions-based mission, provide a persuasive voice at key echelons of influence in the [Army Medical Department], and innovate doctrine to blueprint the future of the ANC" (Army Nurse Corps 2009). The challenge for Army Nurse leaders at all levels is to put the Campaign Plan into action, actively working to prepare the ANC for the future.

Leader Development in the Army

Leader development is defined in Army Regulation 600-100 as, "the deliberate, continuous, sequential, and progressive process, grounded in Army values, that grows Soldiers and civilians into competent and confident leaders capable of decisive action" (Department of the Army 2007c). Organizationally, the Army invests large amounts of time and money so that the officer, at multiple levels, receives the requisite development in three domains (institutional training and education, operational assignments, and self-development) to prepare the officer to function at the next level within the organization (Department of the Army 2007a; Department of the Army 2007c; Wardynski, Lyle, and Colarusso 2009). The operational assignment may be the most important of the three developmental domains as it allows the officer to put into practice the knowledge acquired through the other domains of development. Key to growing during the

operational assignment is the feedback an officer receives from superiors, peers, and subordinates, all of which can be captured through the formal counseling process.

Army Regulation 600-100 refers to the processes of counseling, coaching and mentoring as "developmental multipliers that can enhance and influence maturity, self-awareness, adaptability and conceptual and team-building skills in all leaders" (2007c, 6). Keeping in mind the strategic importance of preparing junior Army Nurses for future responsibilities and operations, the senior Army Nurse must deliberately use these processes to engage junior Army Nurses. The caliber of the junior officer is truly affected, and measured, through these processes. Unfortunately, while informal coaching and counseling occur on a daily basis, recent evidence demonstrates that the formal processes do not occur as is expected in the Army today (Nieberding 2007).

Counseling of Army Officers

Army officers today are not counseled according to regulation, which dictates that an officer be formally counseled by his immediate supervisor "within 30 days" of the junior officer's arrival to organization (Department of the Army 2007d, 4). In this session, the senior officer outlines the junior officer's duties and responsibilities, as well as any specific expectations that the senior officer may have for the new member of his team. Additionally, the pair dialogues to identify the junior officer's short and long term goals, personally and professionally. Throughout the remaining portion of the junior officer's rating period (which is twelve months from his arrival at the unit, or from his most recent evaluation report), the senior officer is expected to formally counsel his subordinate officers quarterly (Department of the Army 2007d). The absence of these sessions leaves the junior officer without the opportunity to obtain direct critique on his

performance and his level of professional maturation. Additionally, the junior officer loses the opportunity to garner from his superior officer the direction and insight into his career development that a junior officer needs to grow into an adaptive and effective leader.

Research Question

Senior officers in the ANC are also concerned about this growing, Army-wide trend. Many are sure that the failure to effectively counsel junior Army Nurses causes unprepared officers to be promoted and assigned to positions of increasing responsibility without the requisite training, counseling, coaching, and mentoring for such assignments (Funari 2009; Nagra 2011). The assignment of junior Army Nurses to leadership positions for which they are unprepared is an unfair practice that pits the junior officer and his subordinates against each other in the workplace. The subordinates expect a certain level of competence and expertise from their new supervisor. The junior Army Nurse, however, cannot perform to that expectation because his experiences and the poor development throughout his career have not prepared him to take charge of an organization. Should the lack of mentorship continue throughout the officer's career, he might develop bad leadership habits that are perpetuated.

A lack of leader development at each level in the Army Nurse's career fails to provide the officer with the feedback and direction that could make him, and the organizations he may lead, successful. The ANC, to meet the intent of its chief and the future needs of the Army, must seed the ANC with adaptive leaders at the earliest stages of their career. This thesis provides one answer to the following question: how should the ANC develop adaptive junior leaders? To fully address the research question and then

propose a solution, the thesis also addresses two secondary research questions. Why are leadership assessment and development important to the ANC? And, how is the effectiveness of leadership development measured in the ANC today?

As a part of the *ANC Campaign Plan*, senior and mid-grade Army Nurse leaders came together to update the former ANC lifecycle model, resulting in the ANC Leadership Capabilities Map (LCM). The LCM aligns the Army Nurse with the professional traits or capabilities that he should possess given his time in service and/or his rank (Dunemn et al. 2011; Funari, Ford, and Schoneboom 2011). These capabilities, achieved through the effective development of junior Army Nurses by their superiors, provide the Army Nurse with the experience and skills to lead in his future assignments. To develop adaptive Army Nurse leaders, senior leaders must develop their subordinates in a manner that considers the LCM. To facilitate this, the author proposes the use of a LCM-based counseling tool, to be used in conjunction with pre-existing leadership feedback tools (introduced in chapter 3), that will guide the senior Army Nurse through the counseling process, ensuring the junior officer receives counseling that is deliberately aimed toward his development as an adaptive leader.

Scope and Delimitations

This thesis focuses only on the development of Army Nurses. It cannot be generalized to encompass the leader development of the entire Army officer pool. Even though the ANC is a subcomponent of the Army and the Army Medical Department (AMEDD), the leadership development of the Army Nurse is unique in its considerations for the professional Registered Nurse. Most of the professional training requirements of an Army Nurse, for example, do not apply to the Army infantry officer, just as a majority

of the infantry officer training requirements do not apply to the Army Nurse. It is this nesting within the Army-wide system and the specialization of the Army Nurse that restricts the subject of this thesis to the ANC only. Similarly, this thesis cannot be generalized to include the development of Department of the Army civilian registered nurses. At this time, civilian registered nurses in the AMEDD are the clinical backbone of the clinical organization and, as such, their development is not structured to focus on leadership development as much as it is clinical skill development. The Army regulations and practices described in this thesis do not apply to the Department of the Army civilian registered nurse.

The proposed LCM-based counseling tool was developed considering the leader developmental needs of Army Nurses through the rank of major. Much of the literature in nursing leadership relates to direct leadership positions in the civilian healthcare community. In the ANC, these positions are most regularly filled by Army Nurses through the rank of major. While extending the tool to include officers of more senior grade is possible, much of the information presented would be largely based on supposition and is less evidence-based. Furthermore, as they are assigned to more advanced and executive level leadership positions, the more senior Army Nurses (lieutenant colonels and colonels) are more regularly supervised by non-ANC officers who would be less familiar with the *ANC Campaign Plan* and the LCM. Thus, an LCM-based counseling tool that extends to the ranks of lieutenant colonel and colonel may be less useful to the senior Army Nurse.

Finally, this thesis addresses the realms of leadership development (institutional, operational, and self-development) only through the eyes of the formal counseling

process. Direct leaders of junior Army Nurses may find it difficult to directly affect all of the realms of leadership development. Through the counseling process, leaders of junior Army Nurses facilitate the junior officer's attendance at various institutional training programs, recommend future operational assignments, and direct the completion of some professional self-development programs. The supervising Army Nurse, however, has no authority over the curriculum of the institutional training, the actual assignment of the junior officer, or the availability of some self-development programs. Through the LCM-based counseling tool, the senior Army Nurse mentors, coaches, and teaches the junior Army Nurse, providing him opportunities to put into practice the adaptive traits he may have recently developed.

Assumptions

To complete this thesis, the author assumes a few points that, should they be proven false, may negatively impact the author's conclusions. First, the author assumes that the senior Army Nurses understand the *ANC Campaign Plan*, what it means to be an adaptive leader, and the basis for the Leadership Capabilities Map (LCM). Senior Army Nurses are expected to familiarize themselves with the tenets of the ANC strategic objectives. One who does not understand the desired end state (in this case, the adaptive Army Nurse leader) cannot guide another officer through the ways and means to arrive at the desired end state. Junior Army Nurses who are counseled by someone who does not understand these tenets may struggle to become the adaptive leader of the future ANC.

Additionally, the author assumes that the senior leader who provides counseling to the junior Army Nurse is within proximity to the junior officer, and is capable of providing the junior officer with regular, face-to-face, formal counseling sessions. Such

formal counseling provides the officers the opportunity to dialogue, which allows the junior Army Nurse to ask questions of the senior Army Nurse and to help the senior Army Nurse understand his personal desires and needs. Remote counseling, which may occur via telephone, email, or video teleconference (or similar technology), may limit the dialogue and the non-verbal communication between the officers, degrading the effectiveness of the counseling session. Poor counseling will hinder the development of the adaptive Army Nurse.

Finally, the author assumes that an Army Nurse will regularly counsel the junior Army Nurse. Because the junior Army Nurse is typically supervised directly and at the next level by Army Nurses while assigned to a medical treatment facility, this scenario is the basis for the solution proposed in this thesis. There are instances when the junior Army Nurse may be supervised by non-Army Nurses. This typically occurs when the Army Nurse is assigned outside of the AMEDD. Examples include assignments to United States Army Recruiting Command, United States Army Cadet Command, and various deployable elements of United States Army Forces Command (such as a forward surgical team or brigade combat team). Senior leaders in these non-AMEDD organizations may have a different view on the development of an adaptive leader and likely have little understanding of the ANC professional development models. During these assignments, the junior Army Nurse may receive counseling and training appropriate for his grade and experience but will function without deliberate consideration of the *ANC Campaign Plan*.

Limitations

Considering the recent adoption, and current roll out of the LCM, there are no historical benchmarks against which to measure whether Army Nurse leaders are

adaptive (Dunemn et al. 2011). This thesis therefore possesses no pilot or test of the proposed LCM-based counseling tool and, therefore, the author cannot attest to its efficacy to actually develop adaptive Army Nurse leaders. This proposed LCM-based counseling tool provides the foundation for senior officers across the ANC to begin counseling junior Army Nurses regularly. As the LCM is used more broadly, future studies may include measures of a leader's achievement of adaptability and the effectiveness of this instrument longitudinally.

Significance of Study

Tomorrow's Army Nurse is developing today, on the wards of Army medical treatment facilities throughout the world, providing care at the bedside. These young officers may also find themselves spread across the Army and across the globe in positions on the battlefield, such as at a combat support hospital, on a forward surgical team, or on a special operations rescue team. Some may find themselves entering educational positions, teaching enlisted soldiers and younger officers. Others will find themselves near the epicenter of the American government, serving as a member of the White House Medical Unit or as a Congressional liaison. While these officers will save lives on the battlefields of the future, whenever and wherever the mission may take them, the Army Nurse of today and tomorrow will be assigned to positions of responsibility that he may not have anticipated when first commissioned as a young officer. Considering the positions available for Army Nurses today, the ability of tomorrow's Army Nurse to prepare for the certain variety of their career is born in the development of their leadership skills early in their career. This thesis provides today's senior Army Nurse a

method by which he guides subordinate Army Nurses towards the adaptive leadership that will make them successful in the future.

Implementation of this thesis may focus the efforts of today's Army Nurse leaders as they shape the AMEDD in the immediate future. Spurred by this thesis, one may find further research conducted to establishes benchmarks to which ANC leaders may compare junior Army Nurses when considering them for promotion or assignment to various positions throughout the world. If backed by research, the tool proposed herein may become a standard, codified implement for the execution of leader development counseling across the ANC. Minimally, the findings of this thesis will be used to develop future Army Nurse leaders who are adaptive and prepared for their future assignments.

Summary

In any organization, leader development is an important factor in the overall success of the organization. As General Dempsey noted in his 2011 Army Magazine piece, leader development in the Army may be the most important factor in determining the future success of the United States Army. There is little argument that this holds true for the ANC, as well. Major General Horoho's Army Nurse Corps Campaign Plan (Army Nurse Corps 2009) reflects Dempsey's point, and provides the ANC leadership with a direction and purpose in implementing leadership development changes across the ANC.

This thesis is grounded in the *ANC Campaign Plan* and proposes a method the ANC should use to develop adaptive junior leaders. In doing so, this thesis also demonstrates why leadership development and assessment are so important to the ANC and how the effectiveness of leadership development is measured in the ANC today. After a brief description of the thesis methodology, an in-depth review of the literature

defines the term leader development as it relates to the Army and to civilian organizations in general, and then describes the ANC leader development process as it is supposed to occur according to Army regulation. Furthermore, the review of literature describes methods for assessing leader development and then details the importance of leadership development to the Army and the ANC today. Chapter 3 also provides insight into leader development in the ANC today (as it actually occurs) before describing how the ANC actually measures the effectiveness of leadership development today. The author then introduces the LCM-based tool in chapter 4, and links it to the leader assessment methods previously described, asserting that this tool should be used throughout the ANC to develop adaptive junior leaders ready to lead in the full spectrum, unified land operations environment of tomorrow.

CHAPTER 2

METHODOLOGY

Introduction

In response to changes in the operating environment of tomorrow's Army, the 2009 *ANC Campaign Plan* called for the transformation of Army Nurses into "full spectrum leaders, agile and responsive to all conditions-based missions" (Army Nurse Corps 2009a). While the *ANC Campaign Plan* identifies the need to develop Army Nurses who are adaptive to their operating environment, it does not specifically identify the 'way ahead' for the ANC. It was not until the publication of the October-December 2011 issue of the United States Army Medical Department Journal that the specifics of the *ANC Campaign Plan* were described in detail for the entire ANC. Taking direction from the newly published information, this thesis strives to present an avenue for the development of adaptive junior Army Nurse leaders. In this chapter, the author describes the methods used to develop this proposed ANC pathway to adaptive leadership.

Answering the Research Question

Generally, a thesis is formatted into five chapters: the introduction, the review of literature, the methodology, data findings and analysis, and conclusions and recommendations. In a normal thesis, the reader is introduced to the topic in the first chapter; the author establishes his credibility throughout the literature review before outlining the research methodology; in the final two chapters, the author describes the research findings, analyzes those findings, and makes a recommendation for the use of his findings before concluding the thesis. In this thesis, however, the methodology and

literature review chapters are switched (while the final two chapters remain in the normal order) in order to answer the secondary and primary research questions in a logical and sequential order.

In reviewing the literature, the author describes the strategic nesting of the *ANC Campaign Plan* and explains why leadership development is the strategic center of gravity for the ANC. The chapter also defines the term adaptive leadership and then demonstrates the importance of leadership development and assessment in the ANC. The author's presentation of data from previously completed studies in the literature review demonstrates the importance of leadership development to the ANC. These items provide an answer to the first secondary question.

Further in the literature review, the author defines leadership development in the Army. The author introduces Army leadership development as it is described and implemented according to Army regulations and field manuals. In an attempt to demonstrate the unique considerations necessary to develop nursing leaders, the author compares Army leadership development to the leadership development processes of the ANC before demonstrating the shortages inherent in the Army development of junior nursing leaders.

Finally, the author presents in the literature review the answer to the final secondary question. The assessment of nursing leaders in the ANC is presented as the method for demonstrating the efficacy of nursing leader development. The author then introduces four forms of leader assessment currently used to demonstrate the effectiveness of ANC leadership development. These methods include the Practice Environment Scale of the Nursing Work Index (PES-NWI) (Patrician, Shang, and Lake

2010) and the 360-degree Multi-Source Assessment and Feedback (360-MSAF) tool (Department of the Army 2011c), as well as the recently implemented Army Nursing Peer Feedback (Prue-Owens, Watkins, and Wolgast 2011) and the quarterly developmental counseling required in the Army leader development process. Based on these tools, the author discusses effectiveness of the leadership development in the ANC at this time.

The answer to the primary research question is interwoven through chapters four and five. In chapter 4, the author reinforces the focus on developmental counseling, describes the LCM, discusses the leadership attributes assessed by the PES-NWI, the 360-MSAF, Army Nursing Peer Feedback, as well as supervisor observation, and then establishes a link between these assessment tools and the LCM. The linkage is proposed in a format that can be used by senior Army Nurses in developmental counseling sessions that provide deliberate leadership development guidance to junior Army Nurses. Further, the author identifies training, experiential, and counseling opportunities the junior Army Nurse may be provided to enhance his adaptability and his overall professional development. To demonstrate the use of the proposed LCM-based counseling tool, the author uses pre-existing PES-NWI data and 360-MSAF data to identify areas of developmental concentration for a notional Army Nurse.

After introducing the LCM-based counseling tool in the previous chapter, chapter 5 seeks to provide legitimacy to this counseling tool. The author analyzes the tool in terms of the screening criteria of the military decision-making process. The application of these criteria (feasibility, acceptability, suitability, distinguishability, and completeness) (Department of the Army 2011d) to this tool provides the reader a framework from which

to judge the appropriateness of the tool's use. The author reiterates the importance of ANC leadership development to the AMEDD mission and the *ANC Campaign Plan*. Finally, the author provides recommendations for the use of the LCM-based counseling tool in the ANC and proposes further study of the topic to prove the efficacy of the concept.

Summary

The development of adaptive leaders in the ANC is essential to the success of the ANC and the 2009 *ANC Campaign Plan*. To answer the primary research question, in the literature review, the author answers the secondary research questions and establishes the challenges of building adaptive ANC leaders in the Army today. Subsequent chapters provide the author's solution to the primary research question. In chapter 4, the LCM-based counseling tool is presented after synthesizing current literature. In chapter 5, the LCM-based counseling tool is established as an appropriate solution to the research question.

CHAPTER 3

REVIEW OF LITERATURE

Introduction

> [T]he ambiguous nature of the operational environment requires Army leaders to know themselves and deal with circumstances as they are.
>
> — Department of the Army, Field Manual 1, *The Army*

The operational environment of the future may present to Army officers scenarios never before considered. Rather than wholly relying on past experience and previously known "best practices" to make decisions, Army leaders must prepare themselves to address new challenges using critical thinking and mental agility. Preparing officers to lead in this way poses a challenge to senior Army leaders who themselves developed in the primarily linear, Cold War era of major combat operations. A growing body of literature over the last several years highlights this challenge and presents proposed solutions to the senior Army leaders for consideration. However, considering the unique mission of the AMEDD and the ANC–that is, executing its war-time mission (patient care) around the clock, even while not in a deployed setting–the challenge of developing Army Nurses cannot be adequately addressed simply by adopting potentially new Army-wide policies and procedures aimed at developing adaptive combat arms officers. The ANC must analyze its mission and develop a system of leadership development that allows for mission accomplishment concurrently with the development of its junior officers.

This review of the literature serves a dual purpose. First, the author establishes the need for changes in the way junior Army Nurse leaders are developed. The author

accomplishes this by nesting leader development within the United States *National Security Strategy*, defining adaptive leadership, performing a center of gravity analysis on the ANC, describing the negative impact of a cycle of poor leadership, and referencing quantitative data that establishes leader development weaknesses in the Army and the AMEDD. The second purpose of the literature review is to answer the secondary research questions. The author accomplishes this by describing current leader development in the Army and the ANC, and then describing how the efficacy of leader development is measured in the Army and the ANC. Through this sequence of information, the author prepares the intellectual landscape for the presentation of the LCM-based counseling tool in the fourth chapter of this thesis.

Review of Literature

Importance of Leader Development

Before delving into the intricacies of the LCM-based counseling tool, one must understand why leadership development is so important to the Army, or any other organization. Certainly, the positive effect of leadership is the accomplishment of a mission or goal. Leader development prepares junior officers to face the challenges of accomplishing their mission at various stages in their career. There are negative effects of leader development as well. Those effects fester when the development is poorly administered or completely absent, resulting in toxic leadership or a self-perpetuating poor leadership that sets the organization up for failure. Assessing leaders and providing them candid feedback allows the leader to understand his effect on those he is trying to lead, identifies negative leadership behaviors, and reinforces positive leadership

behaviors. The effect of such leader development on the Army's desired end states cannot be understated.

Nesting Within the Army Strategy

To properly frame the importance of leadership in the ANC, one must first understand the importance of leadership at the national (strategic) level the government of the United States. In his most recent *National Security Strategy*, President Barack Obama emphasized the need for American leadership throughout the world in order to preserve stability and freedom in regions desperate for assistance (Office of the President of the United States 2010). On nearly every page, the President highlights ways in which the world of today is different than the world of yesterday, as well as the ways in which the world will continue to change. The President's belief in a changing international environment, defined by continued globalization and economic interdependence, provides a continued need for a military state of readiness that accounts for the evolution of a potential unknown operating environment.

Emphasizing the importance of American military leadership on the international stage, the *2011 National Military Strategy* is subtitled *Redefining America's Military Leadership* and establishes how military leadership will "adapt to a challenging new era" (Department of Defense 2011c, cover letter). Supporting the President's strategic guidance, the Chairman of the Joint Chiefs of Staff delineates the important challenges facing the American military forces in the changing global environment, specifically noting that American forces will be called upon to counter violent extremism, deter and defeat aggression, strengthen international and regional security, and shape the future military force. In shaping the force, the Chairman states, "we must grow leaders who can

truly out-think and out innovate adversaries while gaining trust, understanding, and cooperation from our partners in an ever-more complex and dynamic environment" (Department of Defense 2011c, 16). From this document, the Army takes its strategic guidance in preparing the organization for future missions.

In a joint statement to the 112th Congress, the Secretary of the Army and the Chief of Staff of the Army presented the 2011 *Army Posture Statement*, outlining their intent to prepare for future missions within the scope of the guidance provided by the President and the Department of Defense (Department of the Army 2011b). In a comprehensive document, the Army leaders describe the organization's efforts in two concurrent wars, highlighting that the Army had 229,940 soldiers in nearly 80 countries worldwide, and must continue to recruit, retain, care, support, and sustain soldiers and their families in preparation for the evolving missions of the future. Though not mentioned in either of the previous documents, the Army leadership specifically mentions the fiscal restraints foreseen in the coming years as a tool to emphasize the importance of leadership to the organization. It is under these circumstances that the Army sets out to develop "agile and adaptive military and civilian leaders who are able to operate effectively in Joint, interagency, intergovernmental, and multi-national environments" (Department of the Army 2011b, 9).

Nested within the strategic concepts outlined in these documents, the AMEDD supports the Army and Department of Defense vision through its mission to "promote, sustain, and enhance soldier health; train, develop, and equip a medical force that promotes full spectrum operations; and, deliver leading edge health services to our warriors and military family to optimize outcomes" (Army Medical Department 2011).

The AMEDD Strategy Map (see Appendix D) graphically represents the AMEDD mission and identifies the ways and means by which AMEDD will achieve the ends necessary to support the Army vision. Reflecting the importance that leadership holds in the AMEDD, the Strategy Map identifies the need to "improve training and development" as a means to reach the AMEDD strategic end. According to the Strategy Map, improved AMEDD training and development is one of the resources the AMEDD can leverage to achieve its strategic end state (Army Medical Department 2011). This point on the Scorecard refers not only to clinical training and development, essential to the delivery of patient care, but also to the training and development of AMEDD leaders who ensure that patient care is delivered in the safest, most cost effective, and clinically appropriate manner under the fiscal restraints set forth by Army and Department of Defense leaders.

On 28 October 2008, ANC leaders from throughout the AMEDD convened to finalize the *ANC Campaign Plan* (Horoho 2011). The *ANC Campaign Plan* (Army Nurse Corps 2009) underscores the ANC position within the strategic framework of the *National Security Strategy*, the *National Military Strategy*, and the *Army Posture Statement*. The ANC, as an element of the AMEDD, supports the Army mission by providing patient care across the range of military operations, in the United States and abroad, while facing challenges (war and deployments, patient and family care needs, supply and demand of Army Nurses, workload quality and quantity, and leader development) that pose a threat to the ANC mission (Horoho 2011). To most effectively prepare for the broad spectrum of missions–and the challenges–for which the Army

Nurse may be called, the ANC must develop leaders who are capable of adapting to the range of military operations in varying environments.

Adaptive Leadership Defined

Why is it that adaptive leadership has become such an integral part of the Army leadership today? What is it about adaptive leadership that is different from the methods used by Army leaders in years past? To answer this, let us first define adaptability. According to a trio of United States Military Academy economics professors and retired Army officers, Casey Wardynski, David Lyle, and Michael Colarusso, "Adaptability is the ability to develop mental acuity and agility that moves one to achieve equilibrium" (2010a, 14). In this definition, one might view equilibrium to be a level of normalcy, or perhaps, the absence of chaos. Whatever the view, in equilibrium one has the ability to interact with his environment in a controlled and thoughtful manner. The benefit to adaptability, according to Wardynski, Lyle, and Colarusso, is that "The more adaptable [one becomes], the more rapidly one achieves equilibrium" (2010a, 15). In the operating environments described in the strategic documents previously mentioned, Army officers may find themselves in chaotic, unknown scenarios that require one to achieve equilibrium before effectively interacting with operating environment and succeeding at his mission.

Outside of the Army, there are a number of organizations that discuss the term "adaptive leadership." The definition of the term, however, is rather difficult to find. A simple Internet search for the exact term results in a list of 105,000 items. Many of the results are repetitive items, some referring directly or indirectly to many of the same sources. One of the most frequently cited authorities on adaptive leaders and adaptive

leadership is Harvard professor and psychiatrist, Ronald A. Heifetz, who is often credited with creating the term “adaptive leadership” (Uhl-Bien, Marion, and McKelvey 2007) and argues that adaptive leadership works “best when the solution is unknown and participants [have] to be drawn together to discern a new pathway” (Roberts 2007). Army officers will experience scenarios within the future operating environment that are so complex that solutions to challenges within the scenario cannot be found in their learned skill-set of best practices. Adaptive leadership, then, will be the only way for officers to discern a new solution that will restore equilibrium within the environment and set conditions for mission accomplishment.

Another frequently cited authority is Dr. Charles Albano, who operates a consulting firm, Adaptive Leadership. He notes that adaptive leadership is different from traditional, mechanical leadership because large, mechanical organizations are “muscle-bound” (Albano 2007). These organizations are over-regulated and bureaucratic, and they work best in very stable environments. Albano further asserts that adaptive leaders, and adaptive organizations, are characterized by leaders who:

- Think and act to exert strategic influence on their environments. They act to assure that their organizations are well positioned competitively.
- Are proactive, foresee opportunities and put the resources in place to go after them.
- Employ a broad-based style of leadership that enables them to be personally more flexible and adaptive.
- Entertain diverse and divergent views when possible before making major decisions.
- Can admit when they are wrong and alter or abandon a non-productive course of action.
- Are astute students of their environments.
- Can generate creative options of actions.
- Build their organization’s capabilities to learn, transform structure, change culture, and adapt technology.
- Stay knowledgeable of what their stakeholders want.

- Are willing to experiment, take risks.
- Strive to improve their personal openness to new ideas and stay abreast by being lifelong learners.
- Love and encourage innovation from the ranks of their organizations. (Albano 2007)

These characteristics represent a leader who will interact with his environment and establish equilibrium quickly in order to set conditions for mission accomplishment. One might consider the United States Army of yesterday (pre-2001) to be a "muscle-bound" organization but, considering the direction Army leaders are driving the organization today, the Army of the future may not be so inflexible. The traits listed above seem to be congruent with the leadership traits necessary in the Army officer who will lead soldiers in tomorrow's strategic operating environment.

Lieutenant Colonel (retired) Bill Cojocar, a leadership educator and scholar, reinforces the novelty of adaptive leadership as he explains its emergence from situational, transformational, and complexity theories. He credits the military with establishing its own definition for adaptive leadership, stating that the military bases its definition on the practical leadership experiences of those who have operated in "highly complex and adverse environments, against asymmetrical and adaptive enemies" (2009). Burpo defines adaptive leaders as those who conquer the nonlinearity of a chaotic system (2006, 65)–a system that appropriately reflects the Army operational environment of today and tomorrow. In a time of protracted war, the Army has re-focused on its leadership as the cornerstone of the organization. Senior Army leaders recognized that officers who understand the changes in the operating environment, influenced by the stress of an extended period of conflict, must lead the organization and its soldiers (Department of the Army 2006, 10-8; Department of the Army 2007c, 2). Adaptive

leaders are agents of change who use different methods to influence their organization, depending on the situation and the venue. Adaptive leaders are "comfortable with ambiguity . . . flexible and innovative" (Department of the Army 2006, 10-8). Army leaders believe that the adaptive leader will establish equilibrium within their environment and provide the organization the greatest opportunity for success in the future strategic operating environment.

The operating environment for AMEDD and ANC leaders will be no less ambiguous that of the Army combat arms officer. To reflect the importance of leadership in the ANC, the 2009 *ANC Campaign Plan* calls for the creation of

> full spectrum leaders; who are creative thinkers, intrepid explorers, who can see beyond what is today to shape the future, who are adaptive to any conditions-based mission, provide a persuasive voice at key echelons of influence in the AMEDD, and innovative doctrine to blueprint the future of the ANC. (Army Nurse Corps 2009a)

In keeping with the ambiguity of "adaptive leadership," this call to action is somewhat vague in its definition of the end-state for Army Nurse leaders. To more fully define "adaptive leader" and the desired end-state for the Army Nurse leader, Major Tamara Funari, an Army Nurse and Command and General Staff College graduate, surveyed 15 senior Army Nurses (lieutenant colonels and colonels), who noted that junior Army Nurses lacked the ability to lead adaptively (2009). From her research, Funari developed a definition of the adaptive Army Nurse leader. She defined the adaptive Army Nurse leader as

> one who is a clinical expert and can alter leadership styles to be effective across the horizontal and vertical organizational structures to meet the full spectrum operational mission. The adaptive leader is effective in both garrison and austere deployment environments. The adaptive [Army Nurse] leader must be knowledgeable in Army and Joint doctrine, must understand the strategic and

> operational objectives of the Army, and has the ability to view problems holistically and turn ambiguous challenges into opportunities. (Funari 2009)

Funari's definition is one that directly defines the adaptive leader and fully identifies how Army Nurse leaders are expected to relate to each other, to the Army as a whole, and to their patients. The desired end-state for this thesis is to develop Army Nurses who lead in a manner that is consistent with the Funari definition of the adaptive Army Nurse leader.

Center of Gravity Analysis

To reinforce the strategic nesting of Army Nurse leadership development as it is described above, one can view such leadership through the lens of a center of gravity analysis. In military terms, the center of gravity is "a source of power that provides moral or physical strength, freedom of action, or will to act" (Department of Defense 2011b, III.22). In an adversarial relationship, the center of gravity is that which an opposing force may focus its efforts in order to defeat or disrupt its enemy. At the strategic level, the center of gravity of a nation state may be its military, its political leaders, its economy, or its national will (Department of Defense 2011b, III.22). This list is not inclusive. The center of gravity is enabled by certain critical capabilities without which the center of gravity does not function. These capabilities must be present in order for the nation state to accomplish its strategic objectives (Department of Defense 2011b, III.24). If the strategic center of gravity of a nation state is its military, the critical capability may be the navy. To operate as it is intended, this critical capability needs certain resources. These resources are known as critical requirements (Department of Defense 2011b, III.24). In keeping with the naval example as a critical capability, a corresponding critical

requirement might be seaports, for without the ability to dock, a naval fleet would be hard-pressed to refuel, reequip, and load personnel.

The center of gravity, and the corresponding critical capabilities, varies depending on the perspective of those doing the analysis. From the operational perspective, the center of gravity of a military adversary may be its armored division or its fighter jets. In the case of the armored division, a corresponding critical capability may be its integrated air defense system. A critical requirement might be the division's mobile rocket launchers (Department of Defense 2011b, III.25). Understanding the critical capabilities and the critical requirements of an institutional center of gravity provide leaders a framework from which to target their efforts to upend their adversary. If taking a reflective look at their own institutions, leaders more effectively understand where to improve or strengthen their critical capabilities and requirements.

In his *National Security Strategy*, President Barack Obama does not name the United States military as a strategic center of gravity. He does not directly name a center of gravity at all. This may be intentional so as not to place a target on an American institution. Rather, the President infers that the military is the critical capability that enables the unnamed American center of gravity to function as it intended to (Office of the President of the United States 2010). Similarly, the *National Military Strategy* does not identify a military center of gravity but identifies that military leaders must be adaptive and agile in order to effectively lead America's military service members in the changing environment of tomorrow (Department of Defense 2011c). The author of the *National Military Strategy*, the Chairman of the Joint Chiefs of Staff, completed a center of gravity analysis based on the President's *National Security Strategy* and identified that

the military leader—an adaptive military leader—is a critical requirement for an effective military force. From the Chairman's perspective, to harden the unnamed military center of gravity, the military services must strengthen that critical requirement.

In this construct, the AMEDD and the ANC are critical capabilities of the Army. To remain a powerful instrument of American influence throughout the world, the Army must maintain a level of medical readiness that ensures its soldiers are able to respond when called upon. The *ANC Campaign Plan* and the subsequent ANC Balanced Scorecard (see Appendix A) identify the development of leaders as critical requirements for the ANC to accomplish its mission (Army Nurse Corps 2009a). Recognizing that these requirements are a reflection of the center of gravity, and following the idea that one who looks to target the critical requirements of a center of gravity can strengthen or weaken the center of gravity by effecting a critical capability or critical requirement, strengthening the leadership capabilities of Army Nurses will in turn strengthen the ANC, the AMEDD, and improve the readiness of the Army as a whole.

Cyclic Poor Leadership

A failure in leadership weakens the critical requirements and critical capabilities of a military unit, thereby risking the readiness of the organization. For such a failure to occur in the AMEDD is not an unknown possibility, even at the highest levels of leadership. In February and March 2007, Walter Reed Army Medical Center became the focus of a great deal of attention for the alleged conditions under which wounded warriors were being provided care (Abramowitz and Vogel 2007; White 2007). The "scandal" (as it has been called) resulted in the eventual removal or resignation of two senior AMEDD officers and the resignation of then-Secretary of the Army Francis

Harvey (Abramowitz and Vogel 2007; White 2007). Perhaps a symptom of the "muscle-bound" organization to which Dr. Albano referred, the scandal, prompted a quick response from senior Army and Pentagon leadership to change many bureaucratic processes related to the care of wounded soldiers returning from combat. This scenario calls into question the effectiveness of Army medicine in the eyes of many, to include those in Congress (Abramowitz and Vogel 2007; White 2007). Such a weakness in an Army critical capability (the service's ability to care for its wounded soldiers) and in an Army critical requirement (the service's senior medical leadership) potentially threatened the readiness of the organization.

Evidence of this threatened readiness can be seen in another, more recent failure in AMEDD leadership. On 5 November 2009, in the AMEDD-run Soldier Readiness Center on Fort Hood, Texas, Major Nidal Hasan allegedly opened fire on soldiers and civilians at the clinic (Department of Defense 2010). Subsequent reports on the events by the Department of Defense (2010) and Senators Joseph Lieberman and Susan Collins (2011) placed heavy blame on AMEDD leadership. The Department of Defense report asserts that Hasan's supervising AMEDD officers failed to identify and act upon signs that Major Hasan posed a threat to the organization (2010, 9). The Lieberman and Collins report notes that Hasan's actions while in active service to the Army were not in keeping with the "strict officership and security standards" of the Army and that his chain of command failed to act appropriately to document his actions or otherwise discipline Major Hasan (2011, 8, 46-49). Should his actions be proven in court, Major Hasan would be the most prominent evidence of a fractured, bureaucratically bound leadership development system in the AMEDD.

Poor leadership often comes from those who are overwhelmed by the complexity of a system. According to Karlene Kerfoot, a nursing executive and associate dean of nursing practice at the Indiana School of Nursing, these leaders suffer from "cognitive lock," a frame of reference that filters out any information that conflicts with their view of reality, thereby simplifying the complexity of their world (2004). Kerfoot also notes that, in filtering their world, however, the leader becomes a defensive leader who fails to identify successes within the organization and stifles innovation (2004). In the case of the Army, the technological advances that have been integrated into "an Industrial Age hierarchal force structure" (Vandergriff 2008) may have slowed down the decision cycle so much that there exists a virtual gridlock in decision-making. Donald Vandergriff, a retired Army officer and leadership educator, argues that this gridlock may come from an overabundance of information that tempts senior Army leaders to micromanage those below them (2008), which in turn causes junior leaders to become hesitant to act without the approval of their superiors. As Kerfoot infers in her "cognitive lock" concept, however, perhaps the delay is resultant of sensory overload on the part of the leader. He has not been conditioned throughout his development process to perform effectively in chaotic, complex systems and is therefore unable to quickly reach equilibrium, to return to Wardynski, Lyle, and Colarusso's discussion of adaptability (2010a).

While the situations at Walter Reed and Fort Hood were by no means the tipping point in the Army's decision to strive to develop adaptive military leaders, it serves to illustrate that no organization is immune to a culture of poor leadership. The phrase "toxic leadership" has been used to refer to many leaders in the Army in recent years. Then Director of Command and Leadership Studies at the United States Army War

College, Colonel George Reed, described toxic leaders in a 2004 issue of *Military Review* as those who have an apparent lack of concern for the well being of their subordinates and possess a personal quality that negatively affects the organizational climate and performance. Such poor leaders foster (knowingly or not) the perception that he is only motivated by self-promotion, which in turn negatively impacts the attrition rate within the organization. Norma J. Murphy and Deborah Roberts, who are nursing educators in the Canadian healthcare system, point out that this self-orientation allows leaders to view themselves as the decision-makers and their subordinates as the "doers." System-oriented leaders, however, view the well-being of the organization as their priority and value the input and actions of all members within the organization (2008). The self-oriented leader may succeed in the short term, but the organization suffers in the long-term.

Over the last several years, the Center for Army Leadership conducted an annual survey on Army leadership. From the collection of years of data, the Center for Army Leadership team developed a typology for the toxic leader in the Army. According to John P. Steele at the Center for Army Leadership, toxic leaders in the Army tend be characterized by four traits. First, toxic leaders tend to be overly controlling, or micromanaging; these leaders trust very few people to do things correctly and are not willing to underwrite the mistakes of their subordinates. Second, these leaders tend to act aggressively towards others, sometimes in a manner that may be considered illegal (physical abuse, sexual harassment, or intimidation). Third, toxic leaders tend to be very rigid in their decision-making and are unable to adapt to changes in their environment. And finally, according to Steele, toxic leaders have a poor attitude and set a poor example for their subordinates (2011).

Toxic leaders in an organization may create a self-perpetuating cycle of poor leadership that has harmful, long-lasting effects on the morale, productivity, and retention of quality personnel (Riley et al. 2011). These traits, often unnoticed by the leader's supervisor, may produce positive mission results and may therefore be rewarded with a promotion or assignment to a key position. Steele notes that perhaps more unfortunate is the chance that, seeing the perceived reward for such acidic leadership, the officer's subordinates may begin to emulate him, thereby positively reinforcing poor leadership within the organization (2011). Furthermore, Steele says, some toxic leaders may become increasingly aggressive leaders as the consequences of their actions decreasingly likely to be punished as they increase in rank or authority (2011).

Study Data

The growing concern about leadership in the Army is not anecdotal. There is statistical data to support the leadership concerns of senior Army leaders. In 2010, as it has done annually since 2005, the Center for Army Leadership Annual Survey of Army Leadership (CASAL) gathered data through an electronic survey sent to active and reserve component Army leaders (officers, non-commissioned officers, and Department of the Army civilians) with active Army Knowledge Online email accounts. For the 2010 survey, over 22,000 uniformed leaders, and 4,500 Department of the Army civilians, responded to the survey, providing an overall sampling error of plus or minus 0.6 percent, lending a high level of confidence to the findings of the survey (Riley et al. 2011). Indicators from the survey point to leadership as a major concern throughout the organization. In summation of the raw data, Ryan Riley, a leadership analysis consultant contracted to the Center for Army Leadership, and his colleagues note that

> Over 40% agreed that, “The Army no longer demonstrates that it is committed to me as much as it expects me to be committed.”
> About one-fourth (24%) of Army leaders believe that honest mistakes are held against them in their unit/organization. Nearly one-third (30%) believe that their unit/organization promotes a zero-defect mentality
> About one in five Army leaders report that their immediate superior demonstrates toxic leadership behavior. Four out of five Army leaders (83%) report observing a leader who demonstrates toxic leadership behavior in the past year.
> Less than two-thirds of Army leaders are rated as effective at developing their subordinates (61%) and at creating or identifying opportunities for leader development (59%). Institutional courses/schools are not seen as effective in preparing leaders to develop their subordinates.
> The percentage of Army leaders who report that their unit/organization places a high priority on leader development is at an *all time low of 46%* . . . only 57% of Army leaders report that they have time to carry out the duties and responsibilities for developing subordinates. (2011, Main Findings)

To further support the assertion that leadership in the Army is a concern, in a document that accompanies the previously cited CASAL report, Steele (2011) points out that 42 percent of the respondents indicated they perceived toxic leadership to be a serious problem in the Army. This data provides little doubt that leadership in the Army is a major concern for the Soldiers and civilians within the organization. Leaders at all levels in the Army are finding it more and more difficult to provide the leadership they want to provide and do not receive the leadership they believe they deserve.

With such data providing a fairly bleak look into the leadership environment in the Army, one may wonder if there is an answer to such a complex problem. On 18 November 2011, General Robert Cone, the current commanding general of TRADOC, received a list of 28 initiatives aimed at changing the leadership environment in the Army (Tan 2011). Not yet made public, the initiatives proposed by the group will be formally presented to the Department of the Army on a future date. A cadre of 76 junior officers, warrant officers, and non-commissioned officers attended the Army Profession Junior Leader Forum at Fort Sill, Oklahoma and developed the initiatives. According to

journalist Michelle Tan's article in the *Army Times*, the sentiment of this group was very much in line with the data reported by Riley and Steele. An indicator that the Army is falling prey to the "muscle bound," technologically burdened organization described by Albano (2007) and Vandergriff (2008), this group of junior leaders expressed a disdain for "electronic leadership" (Tan 2011). Leadership through email, PowerPoint presentations, and "push-down type" programs underwhelmed these junior leaders (Tan 2011). Perhaps this electronic leadership is an attempt on the part of the senior leaders to harness what may seem like a chaotic system but instead, such a style seems to cause Kerfoot's "cognitive lock" (2004). Instead, these junior leaders assert, Army leaders should return to "show-your-face leadership," or "mentorship, coaching, and relationships built through engaged, face-to-face leadership" (Tan 2011). The Forum attendees want to be able to see their superiors and be able to read the non-verbal cues that accompany their spoken word. These junior leaders want to know that their superiors fully understand the challenges of the operating environment in which the junior leader finds himself. The "electronic leadership" noted in Tan's article puts a geographic distance between the junior and senior leader that is difficult to overcome without the engaged leadership proposed by those in attendance at the Army Profession Junior Leader Forum.

Leaders in the AMEDD face many of the same challenges as those faced by the Army at large. Certainly, of the 22,000 respondents to the CASAL study, a percentage of the respondents were AMEDD officers and soldiers. The Army Nurse respondents numbered 399 and came from all officer ranks and specialties (Center for Army Leadership 2011). On a Likert-scale, 42.2 percent of Army Nurses responded negatively

(very ineffective, ineffective, or neither effective or ineffective) to the question "how effective is your immediate superior at creating or calling attention to leader development opportunities in your current assignment." On a slightly different Likert scale, 42.1 percent of Army Nurses responded negatively (strongly disagree, disagree, or neither agree or disagree) to the statement "while in my previous position, my immediate superior actively prepared me to assume a higher level of responsibility or leadership." Perhaps most concerning, when asked "in your current unit or organization, to what extent do leaders develop the leadership skills of their subordinates," 68.9 percent of Army Nurses responded fairly negatively (not at all, slight extent or moderate extent). Furthermore, 50.3 percent of Army Nurses responded negatively (strongly disagree, disagree, or neither agree or disagree) to the statement "members of my unit or organization who are promoted are prepared to lead in their new assignment" (Center for Army Leadership 2011). This data, while not inclusive of all the Army Nurse data contained in the 2010 CASAL study, indicates that the AMEDD, and more specifically the ANC, suffers from leadership development inadequacies that parallel those of the larger Army.

There are, however, some differences between the AMEDD and the Army at large that must be accounted for. In response to the "scandal" at Walter Reed and the shootings at Fort Hood, the Army conducted two separate studies that focused on leadership development in the AMEDD. These studies, conducted separately by the Center for Army Leadership and the AMEDD Center and School, found that because of the "unique nature of the AMEDD patient care mission" (Center for Army Leadership 2008, 2.1-2.2), AMEDD leaders are forced to stretch their most precious, and yet most limited, asset

(human capital) across a widening clinical mission requirement while also maintaining the leadership development requirements of the Army (Bolton et al. 2011; Center for Army Leadership 2008). AMEDD officers attend institutional, professional military education at a rate that is significantly less than other Army branches (Center for Army Leadership 2008). Furthermore, AMEDD assignments (which are primarily in medical treatment facilities) provide few opportunities for the unique operational assignments that truly provide for the development of strong, adaptive leaders. Those self-development programs that are available in the AMEDD tend to be focused more on maintaining the officer's clinical skill proficiency than on leadership development (Bolton et al. 2011; Center for Army Leadership 2008). Such a focus on the clinical mission places great tension on the leadership development capability of the organization. Given the choice between developing junior AMEDD leaders and sacrificing patient care, senior AMEDD leaders make the only choice available–leader development will be sacrificed in order to care for the patient. A failure in patient care runs counter to everything that health care providers are sworn to uphold. In reflecting on the data presented here, and the experiences at Walter Reed and Fort Hood, the AMEDD has come to realize that leadership development is as important to the success of the patient care mission as one's clinical skill proficiency.

Leader Development in the Army

The Army has long recognized the importance of leadership development in its ranks. A recent release by General Raymond T. Odierno, the 38th Chief of Staff of the Army, emphasized the point as he made an Army priority the development of leaders who possess an "open and adaptable mind, a willingness to accept prudent risk in

unfamiliar or rapidly changing situations, and an ability to adjust based on continuous assessment" (Odierno 2012). It is not difficult to imagine the chaos that awaits a military without strong leadership. To codify the importance of leadership development in the Army, the service developed two primary publications to ensure a level of consistency across the organization. Field Manual 6-22, *Army Leadership* (Department of the Army 2006) defines Army leadership philosophically, while also providing individual leaders a reference manual to use throughout their career as they lead organizations at the tactical, operational, and strategic levels in the Army. Army Regulation 600-100: Army Leadership (Department of the Army 2007c) focuses on assigning responsibilities throughout the entire organization for the management, development, and evaluation of Army leaders. While other field manuals and regulations also relate to leaders, their duties, and their development, Field Manual 6-22 and Army Regulation 600-100 are the cornerstone leadership documents for the service.

In order to prepare junior Army leaders for future assignments and levels of responsibility, Field Manual 6-22 directs that the senior "leader must invest adequate time and effort to develop individual subordinates and build effective teams. Success demands a fine balance of teaching, counseling, coaching, and mentoring" (2006, 8.1). That time must be invested in accordance to Army Regulation 600-100 but also varies depending on the Army branch. AMEDD officers, specifically Army Nurses, are developed in accordance with this regulation but also have some specific considerations that are described in Department of the Army Pamphlet 600-4 *Army Medical Department Officer Development and Career Management* (2007a). The following sections describe

how leaders are developed Army-wide and then how Army Nurse officer development differs from the other branches of the Army.

According to Regulation

Army Regulation 600-100 directs that the Department of the Army develop "competent and multifaceted military and civilian leaders who personify the Army values and the warrior ethos in all aspects from warfighting, to statesmanship, to enterprise management" (2007c, 1). For officers, this is accomplished through a deliberate process that begins upon an officer's accession into the Army and culminates with the officer's resignation of his commission or his retirement. That deliberate process is "continuous, sequential, and progressive" and occurs in three domains: institutional training and education, operational assignments, and self-development (Department of the Army 2007c, 4-5). There is a single common thread throughout this process and among the three domains: the impact of the individual leader to affect subordinates through counseling, coaching, and mentoring (Department of the Army 2007a; Department of the Army 2007c, 4-5).

In Army Regulation 600-100, the Army defines counseling as a comprehensive, subordinate-focused method of providing individualized feedback to all subordinates. Coaching is the process of guiding someone through the development of new or existing skills that allows the one being coached to identify his current level of skill and then learn how to reach the next level of knowledge or skill. Mentorship is a voluntary, two-way relationship between individuals, beyond the scope of the chain of command, that provides the mentee valued assessment, feedback, and guidance over a period of time (Department of the Army 2007c, 5-6). All three methods of interacting with a subordinate

leader provide a method for supervisors to directly impact the junior leader within the framework of Army leadership development regulations. The following sections explain these processes within the three leadership development domains.

Institutional Training

According to Army doctrine, the service relies upon the standardized construct of institutional training to provide every officer a basic level of professional education (Department of the Army 1994, 9; Department of the Army 2009a, 4). Unfortunately, it seems the Army has struggled somewhat in providing institutional training to its officers in recent years. In their manuscript at the Army War College's Strategic Studies Institute, Wardynski, Lyle, and Colarusso argue that current Army institutional training falls short of preparing Army officers to develop into the adaptive leaders called for in the *National Security Strategy* and *National Military Strategy* due to a "sustained demand for thousands of uniformed trainers in Iraq and Afghanistan" (2010a, 5). As evidence, the trio cites a decline in the conduct of institutional training, delays in updating doctrine and programs of instruction, and an increasing reliance on contract employee support (Wardynski, Lyle, and Colarusso 2010a). While this assessment may be correct, the continued importance of a level of institutional training cannot be discounted. Such a foundation provides every officer a common level of understanding of the service, its mission, and its culture, an understanding that helps to also standardize the decision-making processes and prepares leaders for future duties and various levels of responsibility. And, while the Army has begun to recognize and correct some of the institutional training shortfalls, leaders who counsel, coach, and mentor their junior officers can help to fill the void in any of the institutional shortfalls that may exist.

Army-wide

Officers in the Army are formally developed through the Officer Education System, which begins prior to commissioning, and progresses sequentially throughout the officer's career (Department of the Army 2009a, 66). The system, which is linked to promotions and future assignments, is intended to provide officers with the skills, knowledge, and behaviors appropriate for increasing levels of responsibility and authority (Department of the Army 2009a, 66-67). By providing this baseline knowledge, Army institutional training establishes a reference from which officers can progress through their operational assignments and self-development programs. Senior Army officers can facilitate this progression when they reference Army institutional training while counseling, coaching, and mentoring their junior officers.

Under U.S. law, all Army officers are required to attend an initial military training of not less than 12 weeks (Department of the Army 2009a, 65; United States Code 2006). This requirement is fulfilled by the officer's attendance at the Basic Officer Leadership Course (BOLC) I through BOLC III. BOLC I consists of the pre-commissioning training that an officer receives through his attendance and graduation from the United States Military Academy at West Point, any Army Reserve Officer Training Corps program while attending a college throughout the United States, or the United States Army Officer Candidate School. BOLC II is the branch-immaterial course that introduces and prepares the newly commissioned officer to lead soldiers at the platoon level. BOLC III is the branch-specific course that provides officers with further basic training that prepares the officer to function in the Army in accordance with the expectations of officers within his branch (Department of the Army 2009a, 68-69). At the completion of their attendance at

BOLC III, Army officers are expected to be able to function as an entry-level leader in their assigned branch specialty.

After gaining experience as a second lieutenant, first lieutenant and newly promoted captain, officers are expected to attend the Captains Career Course (CCC). Active duty officers attend CCC "as soon as practical after promotion to captain," which should occur sometime between the fourth and seventh year of federal commissioned service (Department of the Army 2009a, 70). Typically, CCC attendance is branch-specific and occurs in residence (meaning, the officer actually goes to a physical location to attend classes). The CCC is preceded by a distance-learning curriculum that provides all officers with common core lessons, developed by Training and Doctrine Command, to provide knowledge necessary for all captains regardless of their branch. At this level of education, officers develop the skills, knowledge, and behaviors to "lead company-size units and serve on battalion and brigade staffs" (Department of the Army 2009a, 70).

Prior to reaching their fifteenth year of federal service, and after being selected for promotion to the rank of major, Army officers are required to complete an intermediate level education program, commonly known as ILE. Formerly called the Command and General Staff Officers Course, ILE is available either in residence or via distance learning. Army competitive category (ACC) officers will complete the course in residence unless operational requirements prevent the officer from attending, in which an exception to policy may be granted. Special branch officers compete to attend ILE in residence due to a limited number of positions available. These officers will complete ILE through distance learning (Department of the Army 2009a, 71-72). Upon completion of ILE, graduates are academically prepared to lead organizations at the battalion and

brigade level, and are prepared to work on staff at all levels of command in the Army and the Department of Defense.

Also considered a part of the institutional training paradigm, some courses are only for those officers selected to attend. Courses that fall into this category include the Senior Service College (SSC), the Advanced Military Studies Program, and the pre-command courses. The Advanced Military Studies Program provides ILE-graduate officers with an education that emphasizes planning and executing military campaigns at the tactical, operational, and strategic levels of war (Department of the Army 2009a, 72). Officers who are selected to command at the battalion and brigade levels attend a pre-command course, where they are introduced to the basic concepts of command and provide the future commanders time to "reflect on their upcoming duties as it pertains to developing strategic leader capabilities" (Department of the Army 2009a, 73).

Prior to reaching twenty-five years of active federal service, selected officers at the rank of lieutenant colonel or colonel, may be selected to attend a SSC. This level of education, which prepares officers to command or work on staff at the strategic level, is accomplished through the U.S. Army War College or an equivalent college in another Department of Defense service. Some officers may not be selected to attend the U.S. Army War College but may be selected to attend an equivalent program in the U.S. Navy or the U.S. Air Force. Others may choose to participate in the Senior Service College Fellowship Program, which assigns officers as representatives in agencies or organizations outside of the Department of the Army to provide a "vehicle for strategic outreach to facilitate cross-agency networking" (Department of the Army 2009a, 74-75). Officers who graduate from a senior staff college equivalent program are prepared to fill

positions “that requires a thorough knowledge of strategy and the art and science of developing and using instruments of national power . . . during peace and war” (Department of the Army 2009a, 74).

Army Nurse Corps

Some Army officers are not required to complete the same level of training as ACC officers. These officers, who are Special Branch officers, complete the same levels of professional military education as ACC officers but often do so in a manner that is altered to take into account the officer’s professional specialty. AMEDD officers, and Army Nurses specifically, fall into this category of officer. Army special branch officers are required to attend initial military training under U.S. law (United States Code 2006). However, AMEDD officers are granted a special exception under the same law, which allows their initial military training to be less than twelve weeks in length (Department of the Army 2009a, 65). Army Nurses, regardless of commissioning source, complete initial military training by attending the Officer Basic Leadership Course (OBLC) at the AMEDD Center and Schools, Fort Sam Houston, Texas. While attending OBLC, Army Nurses receive a performance-oriented education and initial leader development for newly commissioned officers before taking part in an ANC-specific phase that introduces the officer to the role of the Army Nurse in the Army and the AMEDD (Department of the Army 2007a, 12-13; Department of the Army 2007b, 12).

Army Nurses attend the AMEDD CCC at Fort Sam Houston, Texas, where they receive advanced training in medical combat service support operations. Prior to their arrival at Fort Sam Houston, Army Nurse must complete the Training and Doctrine Command-directed common core curriculum via distance learning (Department of the

Army 2007a, 13; Department of the Army 2007b, 12). Completed in accordance with Army Regulation 350-1, Army Nurses attend the course between the fourth and seventh year of federal service and are prepared for "subsequent assignments by learning the leader, tactical, and technical tasks, including the supporting knowledge and skills necessary to support the Joint Team across the full spectrum of military medical operations" (Department of the Army 2007a, 13).

Army Nurses complete ILE and SSC under similar circumstances, in accordance with the requirements set forth in Army Regulation 350-1 (Department of the Army 2009a, 72-76). All eligible officers will complete ILE prior to promotion to lieutenant colonel. Most will complete this training through via distance learning. Through a competitive, central boarding process, some Army Nurses are selected to attend ILE in residence. Army Nurses eligible for consideration to attend SSC will also be selected by a competitive, central board. Those selected will attend the in residence course (or, an equivalent) while those selected as alternates may elect to take part in the SSC distance education program (Department of the Army 2007a, 12-13; Department of the Army 2007b, 12).

At first glance, the AMEDD professional military education fulfills all of the regulatory requirements for the professional development of junior Army Nurses. Recently, however, a review of the curriculum at the AMEDD Center and School revealed a few distinct differences between the ACC and the AMEDD professional military education. While reviewing the AMEDD Center and School curriculum in response to the November 2009 shootings at Fort Hood, Texas, Colonel Karl C. Bolton and colleagues at the AMEDD Leader Training Center (2010) identified that the

AMEDD OBLC and CCC were distinctly different from the corresponding ACC courses. The courses have been altered from the ACC curriculum to meet the requirements of the AMEDD.

The AMEDD OBLC exists in three different variations. The first variation is primarily for active duty AMEDD officers and consists of a seven week common core course followed by a branch specific training that lasts between one and five weeks. The second OBLC variation is a six-week version reserved for medical and dental students who will serve on active duty after graduating from their respective professional program. The third OBLC variation is reserved for U.S. Army Reserve officers, which consists of a distance learning module and a twenty-six day resident module (Bolton et al. 2010, 12). Active duty Army Nurses typically attend the first variation of OBLC, which lasts nine weeks after adding the two week, branch specific module to the seven week core curriculum. The nine weeks that Army Nurses spend completing the initial military training is three weeks less than the twelve-week training period required by law, as mentioned earlier. According to Bolton and colleagues, 19 percent of the OBLC training focuses on general officership topics and 31 percent of the OBLC training focuses on leadership (2010, 13). Considering that a significant portion of active duty Army Nurses access onto active duty with no pre-commissioning training at all (ie; graduation from a Reserve Officer Training Corps program), the comparatively short OBLC training period and the relatively small percentage of the curriculum that focuses on leadership and officership, Army Nurses begin their career without a thorough understanding of their duties and responsibilities as Army officers. Considering the three phases of BOLC for

ACC officers, they receive nearly three times as much leadership and officership training as an Army Nurse.

The AMEDD CCC is similarly limited in length and depth of the curriculum. The AMEDD CCC is nine weeks in length, compared to the ACC career courses, which are mandated to be between twenty and twenty-one weeks in length. This severely limits the Army Nurse's opportunity for the peer-based learning for which the CCC is designed (Bolton et al 2010, 28). Additionally, the Army Nurses who attend the AMEDD CCC spend 14 percent of the entire curriculum on officership topics and 32 percent of the course on general leadership topics (Bolton et al. 2010, 20). In their review of the AMEDD Center and School curriculum, Bolton and his colleagues expressed their belief that this level of leadership education, coupled with the small class size and peer-to-peer interactions over the nine-week course, is adequate for AMEDD officers. To support their conclusion, Bolton and colleagues cite a 2010 Training and Doctrine Command review of the AMEDD Center and School that determined the AMEDD CCC curriculum adequately prepared AMEDD officers for leading soldiers outside of the school environment (Bolton et al. 2010, 20).

The AMEDD CCC is designed to train all AMEDD officers. However, because the AMEDD encompasses six different professional branches, and dozens of subspecialties, training all AMEDD officers to be completely ready to lead in their professional field is challenging. To more effectively prepare Army Nurses to lead in other Army Nurses in the AMEDD, the ANC operates several short courses out of the Department of Nursing Science at the AMEDD Center and School (Department of the Army 2007a, 116). These courses begin almost as soon as Army Nurses graduate from

OBLC and continue throughout their career. Early in their career, the junior Army Nurse may attend courses that focus on expanding their clinical expertise. After reaching the grade of senior captain or major, the courses available to Army Nurses begin to focus more on leadership development and less on clinical expertise. By the rank of lieutenant colonel, Army Nurses attend training that is almost exclusively leadership focused (Department of the Army 2007a, 119-120).

In 2010, under the direction of the Chief of the Army Nurse Corps, the Department of Nursing Science at the AMEDD Center and School began to develop the Army Nursing Leader Academy at Fort Sam Houston, Texas (Horoho 2011). The academy was established, using the standards from the U.S. Army Learning Concept 2015, to fill gaps in Army Nurse leadership development that exist in already-present courses not administered by the Department of Nursing Science. To identify these gaps, the ANC leadership established an imperative action team of senior Army Nurses who then developed a list of clinical and leadership competencies necessary for Army Nurses to function at the three levels of military leadership (tactical, operational, and strategic). These competencies were incorporated into the LCM (Dunemn et al. 2011). Those competencies drove changes to the pre-existing courses administered by the Department of Nursing Science, ensuring that all identified competencies are included in the curriculum (Funari, Ford, and Shoneboom 2011). The identified competencies will be discussed in greater detail in chapter 4.

In accordance with the design of the Army Nursing Leader Academy, after a second lieutenant Army Nurse completes OBLC, he is assigned to an Army medical treatment facility where he will complete the clinically focused Clinical Nurse Transition

Program (Dunemn et al. 2011). At this point in his career, the Army Nurse is functioning at the tactical level of leadership. After serving as a clinical staff nurse for a period of time, the Army Nurse may elect to attend a specialization course (the specialization is called an area of concentration, or AOC), which is also clinically focused. At some point in his career, Army Nurses may elect to attend a joint course, called the Combat Casualty Care Course, that focuses on clinical care in an austere environment (Department of the Army 2007a, 119).

At the rank of senior captain, or major, Army Nurses typically begin to work in assignments at the operational level of leadership and, therefore, have the opportunity to attend the first iteration of the Clinical Nurse Officer-in-Charge (CNOIC) course in preparation for future positions of direct leadership over junior Army Nurses and Department of the Army civilians. After promotion to the rank of major, the Army Nurse will also attend the second iteration of the CNOIC course (Dunemn et al. 2011). These courses are administratively focused and are designed to provide Army Nurses with skills, knowledge, and behaviors to lead Army Nurses at the tactical and operational level.

Promotion to the rank of lieutenant colonel provides the Army Nurse the opportunity to attend the Entry Level Executive Nursing Course (Dunemn et al. 2011) while still leading Army Nurses at the operational level. Once the Army Nurse begins to lead at the strategic level, as a lieutenant colonel or colonel, he will have to opportunity to attend the AMEDD Executive Skills Course, the Interagency Institute of Federal Healthcare Executives and the Medical Strategic Leadership Program. Though not under the auspices of the Department of Nursing Sciences at AMEDD Center and Schools,

these courses are leadership courses unique to AMEDD officers and other healthcare leaders in the U.S. government and are designed to prepare Army Nurses (and officers of other AMEDD specialties) to lead healthcare organizations at the strategic or executive level of government (Dunemn et al. 2011).

To ensure that the junior Army Nurse fully develops through the institutional domain of leadership development, the officer must to be counseled, coached, and mentored by members of the institutional faculty. While a more senior Army Nurse may not always accomplish this, the process of providing the junior Army Nurse with feedback on his progress through the educational program is essential to the overall development of the officer. When possible, the junior Army Nurse should be counseled, coached, and mentored while considering the junior officer's current and desired future positions on the LCM.

Operational Assignments

Another aspect of Army leader development is the operational domain, or operational assignment. The operational assignment helps officers to

> translate the theory into practice by placing leaders in positions to apply those [skills, knowledge, and behaviors] acquired during institutional training and education. Repetitive performance of duty requirements (practice) refines the leader's skills, broadens his knowledge, and shapes his behavior and attitudes. (Department of the Army 1994, 3)

Army wide, an officer is assigned to positions of increasing responsibility in order to gain experience and prepare him for future positions and future levels of responsibility. The skills, knowledge and behaviors required for one assignment builds on the experiences of the officer in his previous assignments, potentially requiring the officer to call on experiences as far back as his very first operational assignment. In the larger Army,

operational assignments progress from platoon leader, to company executive officer, company commander, battalion executive officer or operations officer, to battalion command, and so on. While serving in the various operational positions, an ACC officer is supposed to be guided through his development by his commander or other supervising officer. While in the operational assignment, the officer should be developed using the various certification programs available in the Army (for example, jump master training or Ranger School), conducting staff rides, sharing experiences, and conducting after action reviews of training events and other experiences (Department of the Army 1994, 11-14).

Operational assignments in the ANC are progressive in nature as well, focusing first on the development of the officer's clinical competencies before transitioning to leadership roles throughout the AMEDD. The tactical level of leadership development should build a strong foundation from which the Army Nurse can build during future assignments at the operational and strategic level of the AMEDD. As a second lieutenant, the Army Nurse is assigned as a clinical staff nurse, a position that provides the newly licensed registered nurse the opportunity to solidify the skills and knowledge acquired during his bachelor's degree program. Additionally, the junior Army Nurse begins to develop basic managerial skills from his duties as the shift charge nurse. He/she will also be assigned duties that begin to introduce the younger Army Nurse to aspects of the operational level of leadership. These duties might include acting as a preceptor to newly assigned staff members, unit in-service coordinator, or an intra-organizational committee member (Department of the Army 2007a, 119). After achieving the rank of captain, Army Nurses may also be assigned to non-clinical positions that provide the officer the

opportunity to develop a different set of skills, knowledge, and behaviors. These positions may include assignments as the CNOIC at a smaller medical treatment facility, as an AMEDD Recruiter in U.S. Army Recruiting Command, or as a ROTC nurse counselor (Department of the Army 2007a, 119). These positions expose the Army Nurse to a non-clinical part of the Army and allow him to develop more broadly as a leader.

Assignments at the operational level of leadership may begin as a senior captain but typically occur at the rank of major or lieutenant colonel. By this point in the career of the Army Nurse, the officer should have a solid clinical background. These positions are less clinically focused and are more leadership focused. Specifically, an Army Nurse at the rank of lieutenant colonel, his assignment is a duty position that requires "officers to demonstrate advanced leadership capability for directing clinical practice and developing leadership skills in subordinate staff" (Department of the Army 2007a, 120). The positions may include the CNOIC at larger medical treatment facilities, the supervisor of multiple nursing units, a career management officer at Human Resources Command, the chief nurse of a forward surgical team or combat support hospital, a staff officer at U.S. Army Medical Command or Office of the Chief, ANC, or an instructor at an ANC-sponsored clinical training program (such as an Army Nurse specialization course or an enlisted medic-related specialty) (Department of the Army 2007a, 119-120). Based on the Army Nurse's AOC, or his professional education and credentials, he may be limited to the operational assignments available to him. For example, a medical-surgical nurse cannot be assigned to work as a nurse practitioner because he has not acquired the appropriate professional credential to qualify to fill that position. Some Army Nurse positions are available to any Army Nurse.

Army Nurses at the rank of lieutenant colonel or colonel may be assigned to positions of leadership at the strategic, or executive, level of the AMEDD. Depending on their AOC and professional credentials, the Army Nurse may continue to be clinically focused (primarily those Army Nurses who are credentialed as nurse practitioners or as certified registered nurse anesthetists) or may shift to an almost exclusive focus on the leadership of organizations at the strategic or executive level. Assignments at this level are designed to "maximize the officer's capabilities to provide the highest level of leadership, critical thinking, and analysis to the ANC, the AMEDD, and Army" (Department of the Army 2007a, 120). Army Nurses at this level may be assigned to positions that include chief nurse of a medical treatment facility, chief nurse of an Army Service Component Command, chief nurse of a medical brigade, chief nurse of a combat support hospital, staff officer at AMEDD, staff officer at U.S. Army Medical Command, staff officer at the Pentagon, and commander of a medical treatment facility (Department of the Army 2007a, 120-121). These positions are generally considered to be AOC-immaterial positions, meaning that Army Nurses of any specialty may be assigned to the position. Furthermore, some positions are also AMEDD branch-immaterial, meaning that AMEDD officers of any branch or specialty may be assigned to the position.

To capitalize on each operational assignment, the Army Nurse must be developed by his senior Army Nurse leaders. As noted earlier, the common thread to all pillars of leadership development is the counseling, coaching, and mentoring of the junior officer. In the operational domain, such efforts provide the junior officer with the opportunity to make permanent the skills, knowledge, and behaviors acquired through the institutional domain of leadership development. Additionally, senior Army Nurses must consider the

LCM when developing their subordinate Army Nurses. Doing so allows the senior Army Nurse to mold the skills, knowledge, and behaviors of the junior officer in preparation for assignments throughout the ANC in the future.

Self-Development

Army leaders must prepare their subordinates for future assignments that will require the officer to lead in a more complex environment and exercise an increasing amount of responsibility. It is the senior officer's responsibility to provide the junior officer the opportunity to learn and grow. It is not, however, the senior officer's responsibility to spoon-feed the junior officer. The self-development domain reinforces this sentiment by directing that the officer assume personal responsibility for one's own learning and development (Department of the Army 2009a, 4; Dunemn et al. 2011). Colonel (retired) Kathleen Dunemn, an Associate Professor of Nursing at the University of Northern Colorado, and colleagues note that self-development occurs through a "process of assessment, reflection, and action" (2011). As a "planned, goal-oriented learning that reinforces and expands the depth and breadth of [the officer's] knowledge base, self-awareness, and situational awareness" (Department of the Army 2009a, 5), the duty of the senior leader, then, is to facilitate this process, guiding the junior officer and providing the feedback necessary for the officer to conduct his self-assessment.

According to Department of the Army Pamphlet 350-58, self-development, an essential part of every officer's development, starts with a self-assessment of the officer's strengths, weaknesses, and developmental needs and continues through the path outlined in the officer's individual development plan (Department of the Army 1994, 18). Prior to the development of the LCM, senior Army Nurses had no standardized tool from which

to base a junior officer's individual development plan. The senior officer counseled his subordinates and guided their development based on personal experience alone. The LCM provides the senior Army Nurse a standardized platform to guide the individual development plan for every junior Army Nurse.

The individual development plan may include one or more of the three self-development categories, as defined by Army Regulation 350-1. A "structured" self-development program is one that consists of required learning on the part of the officer (Department of the Army 2009a, 5). For Army Nurses, this may include gaining the required 20 continuing education contact hours annually (Department of the Army 2007a), or the reading required as a part of clinical certification course (such as that required for advanced cardiac life support certification). A "guided" self-development program is one that provides the officer with optional learning that prepares the officer for changing technical, functional, and leadership responsibilities throughout his career. An example may be the professional reading lists provided by various leaders throughout the Army. A "personal" self-development program is one in which the officer begins the program himself and defines his objective, pace, and process (Department of the Army 2009a, 5). This could encompass any of the previous examples or a plethora more. The key to the final category is that the officer begins the process on his own and keeps himself on track throughout the program.

In the ANC, self-development tends to occur through the officer's involvement with professional organizations, conducting a self-assessment, creating a personal development plan, interacting with a mentor, reading professional journals, becoming clinically certified, and attending clinical or leadership seminars (Dunemn et al. 2011).

The individual development plan may be completed in a number of ways, formally and informally. Until recently, the Army Evaluation Reporting System directed that officers in the ranks of second lieutenant to captain (inclusively) receive formal developmental counseling using the Developmental Support Form (Department of the Army 2007d, 62), which can be used to identify and facilitate an officer's plan for self-development. However, the Secretary of the Army rescinded this requirement in September 2011; a formal development plan is now an optional part of the officer evaluation reporting system (McHugh 2011). Use of a formal individual development plan would likely fall into the category of a "guided" self-development program. Informally, the individual development plan may simply be initiated and facilitated through conversations between the junior and senior officers. Because this could be initiated by the junior officer and not the senior officer, the informal development plan may be a "guided" or a "personal" development program. With the advent of the *ANC Campaign Plan* (Army Nurse Corps 2009a), the LCM should guide the self-development of Army Nurses, whether the senior Army Nurse facilitates the development program or the program is self-initiated.

Some portions of a self-developmental program may fall into another paradigm of professional development. For example, the AMEDD has a formal education program available to all AMEDD officers. This program, called Long Term Health Education and Training (LTHET), provides AMEDD officers the opportunity to attend a healthcare-specific graduate education program in preparation for future positions in the AMEDD (Department of the Army 2007a, 10, 116-128; Department of the Army 2007b, 38). Although doctrinally considered a part of the institutional paradigm of professional development, LTHET may also be considered a part of the self-development paradigm

because participation in this program is voluntary on the part of the officer. Additionally, the officer determines when in his career he would like to take part in this training. And, while his senior Army Nurse may guide the junior officer as to when to apply for, and take part in, LTHET, the application process belongs to the junior officer alone. The involved leadership and guidance of the senior Army Nurse ensures that self-development programs prepare junior Army Nurses to be the adaptive leaders of the future ANC.

Shortages in Development?

The three-domain structure of Army leadership development appears to be very inclusive, at first glance. There are some gaps in the leader development structure as it appears today. In his 2006 article in *Military Review*, then-Major E. John Burpo, a United States Military Academy and Command and General Staff College graduate, acknowledged some of the shortcomings in the Army leader development strategy. In an attempt to define 'the way ahead' for the Army, Burpo correctly asserts that the operational environment is changing and that today's military leaders need to become adaptive leaders, or "captains of chaos," in order to effectively lead in this new operating environment. Burpo was ahead of his time in one respect: he recognized the need for change before most other Army leaders. Unfortunately, his recommendations to change the way leaders are developed defaulted to an organization-wide, one-size-fits-all list that does not reflect the leadership realities of today. Certainly, Burpo's suggestions to diversify the education of military leaders, and alter the curriculum for already-existing institutional training can aide in developing adaptive leaders. By providing more officers a wider variety of experiences, the Army as a whole will become more adaptive. But

Burpo's recommendations fall short in one critical area: recognizing that leadership development is an individual challenge.

Institutional training exists to provide the Army with a standardized set of baseline skills and knowledge. The operational assignments provide context to what each officer learns while taking part in the institutional domain, allowing the officer to internalize and make permanent the lessons of academia and experience. On the whole, varying training and operational assignments may produce a corps of more adaptive officers, as Burpo suggests. On a staff, there will be a wider array of experiences to reference. The staff (at whatever level) will be more adaptable. But, for the individual officer, there will be gaps in his training and experience. He will be no more adaptive than his predecessor. The fill-gap is the officer's individual development plan (the self-development domain).

In 2006, Burpo did not have the luxury of the data sets from several years of CASAL studies (Riley et al. 2011; Steele 2011) or references to the leadership development feedback from junior leaders (Tan 2011). Major Burpo's points were ahead of their time. But, considering the data available today, one must conclude that after altering the institutional and operational assignments to diversify officer experiences, the next step is to focus on improving the development plans for the individual officer. This is done through individualized counseling, coaching, and mentoring on the part of the senior officer. The importance of deliberate, face-to-face interactions (formal and informal) between junior and senior officers cannot be understated and has been the underlying theme of all leadership development literature reviewed to date.

Army-wide

In his 2006 article, Major Burpo makes a laundry list of recommendations to "help officers adapt to social, organizational, and intellectual environments uniquely different from the Army's." The list includes incentivizing language proficiency, incentivizing graduate education, substituting civilian graduate education for some ILE and SSC attendance, and developing a comprehensive professional certification for officers at the end of ILE (2006). While strong recommendations to improve the adaptability of the officer corps as a whole, these recommendations may not work to truly develop adaptive individuals. Burpo recognizes this limitation himself when he states that, "Because it is not possible to prepare every officer for every type of assignment and possible deployment, the Army should seek to develop the minds and leadership dynamics of its future Great Captains" (2006, 69).

Altering the way the Army "evolves adaptability" (Vandergriff 2008) may not be accomplished institutionally. While providing students in an institutional setting with the Adaptive Leader Methodology seems simple enough, it is the internalization of that model that may actually evolve adaptive leaders. As Vandergriff describes it, the Adaptive Leader Methodology was developed by the Army Capability Integration Center Forward, a part of Training and Doctrine Command, based on a model used at the Georgetown University Army ROTC program. The program "develops adaptability through Rapid Decision Making process using the experiential learning model through scenario based learning." The program, which is believed to mimic leader and cognitive development practices in the academic world, "promotes self-actualized learning via weakly structured situational problems" (Vandergriff 2008). Use of the Adaptive Leader

Methodology outside of the institutional environment will solidify its processes for the officer. That alone, however, will not produce adaptive leaders.

To be adaptive, and to overcome adaptive challenges, the Army must change its culture. Lieutenant Colonel Marvin W. Williams, in his School of Advanced Military Studies monograph, defines an adaptive challenge as a problem that persists "even when authority figures and organizations apply best practices and known methods or when standard operating procedures do not solve the problem" (2001, 7). The Army culture today does not provide for this level of adaptability in all aspects of the organization. In the new Army doctrine, the centrality of the commander within the operations process, through mission command, (Department of the Army 2011d) limits the adaptability of the organization. Colonel John B. Richardson, the current commander of the Army's 3rd Cavalry Regiment and a former leadership and management fellow at the Harvard University Kennedy School of Government, alludes to this when he points out "When a problem is too complex for the leader to solve alone, a culture of authority-centric leadership places constraints on finding adaptive solutions" (2011, 14). He argues that, to change the Army culture, the organization should first change its core competencies to reflect the needed change in culture. Colonel Richardson lists three core competencies of the Army: one who leads, one who develops, and one who achieves (2011, 49). To begin the culture shift in the Army, Colonel Richardson endorses the addition of a fourth competency, one who mobilizes, which he defines as one who "navigates through adaptive challenges by confronting people with the reality of changed conditions and provides a learning environment for the group to discover and develop adaptive solutions" (2011, 3).

As noted during the earlier discussion on the study data, institutional development of the leader is not seen as being effective in developing leaders. Operational assignments are the most effective method of developing leaders (Riley et al. 2011). A part of that operational assignment is the individual counseling, coaching, and mentoring the junior officer receives from his senior leaders. Hatfield and colleagues support this, as well, noting that there is a downward trend in the perceived quality of leadership development in the Army professional education system while operational experience (too include feedback from leadership) and self-development have increasing levels of effectiveness in the Army (2011).

The challenge for the senior officer, however, is finding the time to actually spend time with their junior officers. In the 2011 CASAL study, 57 percent of Army leaders indicated that they believe that they do not have the time to "carry out the duties and responsibilities for developing their subordinates" (Riley et al. 2011). Leonard Wong, a retired Army officer and leadership scholar, foresaw this in 2002 when he published a manuscript for the Army War College Strategic Studies Institute, in which he noted that Army officers are overwhelmed by the training requirements and cannot spend time leading as they are trained to. To prove his point, Wong looked at the average calendar year and determined that an Army company commander has 256 days a year available for training (after subtracting 109 days for weekends, federal holidays, payday activities and the Christmas half-day schedule). He then accounted for the number of days necessary to complete all required training as listed in Army Regulation 350-1, various Army policies and directives, and an average command training guidance. The 100 distinct training requirements that Wong identified would encompass 297 days of training – 41 days more

than available in the calendar. Finally, to demonstrate his point even more, Wong reduced the amount of non-mission related training by half. This reduction of apparently unnecessary training still produced a 20-day overage for the Army company commander (Wong 2002). This data, which precedes the Army's involvement in two concurrent wars, is outdated by nearly ten years. In the context of two wars, however, one can conclude that the level of required training has not decreased; if it has changed at all, it has likely increased—perhaps significantly.

Building adaptive leaders in the Army is a challenge because it requires a shift in the organizations culture. The Army must shift from a top-down driven hierarchy to a bottom-up, decentralized organization. Such a shift requires change at all levels of the Army, and may be limited by the hierarchical requirements of the federal government. Understanding that the gaps in the system seem to be at the lowest level of the organization, senior Army leaders can re-focus leaders at all levels and instill the understanding that face-to-face counseling, coaching, and mentoring, coupled with an officers operational assignment, can most effectively shape today's officers into the adaptive leaders necessary to lead in the national security environment of tomorrow.

Army Nurse Corps

As a subordinate unit of the larger Army force, the AMEDD and the ANC are subject to the same challenges and gaps in leadership development as other Army officers. In one sense, however, the AMEDD and the ANC may have a more difficult time developing adaptive leaders. AMEDD commanders have even less training days available to accomplish all required training due to the round-the-clock nature of the AMEDD healthcare mission. Whether at home station, or in a combat zone, AMEDD

leaders must meet the training requirements placed on it by the Army as well as the training and organizational accreditation requirements placed on the AMEDD by external organizations (such as the Joint Commission). In its 2008 review of the AMEDD leadership development challenges, the Center for Army Leadership noted that the "AMEDD is so focused on performing its patient care mission to a high standard that all other demands for training (specifically, leadership training and general management skills) suffer" (2008, 2.1-2.2).

Developing ANC leaders is an imperative that may impact the readiness of the Army as a whole. In the healthcare arena, specifically in nursing, leader development directly impacts patient safety, and therefore, patient outcomes (Page 2004, 108-162; Patrician 2010; Sherman and Pross 2010). Nurses that work in adaptive, permitting environments, where the leaders are well developed and capable of developing others, are happier and more capable of focusing on the mission (patient care). Understanding this requirement, the new patient care model of the ANC, the Patient CaringTouch System, explicitly requires a "healthy work environment" and "capability building" among its leaders (Horoho 2011). To adequately prepare ANC leaders to lead adaptively, and provide the healthy work environment, ANC leaders must continue to address the gaps in the institutional development of leaders through the *ANC Campaign Plan* and the work of the leadership imperative action team. Consistent with the needs of the larger Army, and the data from the CASAL study, the Army Nurse leaders must deliberately use subordinate counseling, coaching, and mentoring to link training received in the institutional domain to experiences in the operational domain and guide the self-development of the junior Army Nurse.

Measuring the Efficacy of Leader Development

Measuring the efficacy of developing adaptive leaders is a relatively new requirement in the Army. Because the concept of adaptive leadership is so new, there are no standards against which to compare the officer. The effectiveness of leaders is generally evaluated in terms of mission accomplishment and toxicity, rather than adaptability. However, the regimented system that is the Army leader assessment system has evolved over time and continues to evolve, as the new adaptive leadership model becomes the standard throughout the Army and the ANC.

Leader Assessment Army-wide

Traditionally, leader evaluations in the Army have relied on a system of annual, formal feedback, after a series of formal counseling sessions, provided to the junior officer by a pair of more senior officers (Williams, M. 2001, 12-15). Detailed in Army Regulation 623-3, this evaluation is primarily used by the Army to make personnel management decisions. The officer evaluation report (OER), as it is called, is also designed to be a "thoughtful, fair appraisal of a soldier's ability and potential" and must be "accurate and complete to ensure that sound personnel management decisions can be made and that a rated soldier's potential can be fully developed" (Department of the Army 2007d, 4). The OER is supposed to be the culmination of a year's worth of formal counseling and informal coaching and mentoring between the rated officer and his rating superior officers. The feedback provided to the officer on the OER serves as the only formal assessment of the officer's performance and potential seen by Army leaders outside of the officer's chain of command.

The evaluation of an officer begins upon the officer's arrival at his duty station, or at the end of the previous year-long evaluation period, whichever is appropriate. Within thirty days from the beginning of the rating period, the junior officer is required to take part in a formal counseling session with his immediate supervisor (or, rater). At this time, the junior officer receives a copy of the mission, vision, and performance objectives of his supervisor (rater) and second-line supervisor (senior rater) (collected on the OER support form for each supervisor). The officers also discuss the duties, responsibilities, and objectives of the junior officer during this counseling session, nesting these items with the duties, responsibilities, and objectives of the more senior, supervising officers. Officers at the rank of captain or below are required to receive repeated counseling sessions quarterly to provide the junior officer guidance throughout the rating period (Department of the Army 2007d, 4). At the end of the rating period (typically a year), the rated officer receives written feedback on his performance and potential from his rater and senior rater using the OER. Once completed, the OER is forwarded to U.S. Army Human Resources Command for inclusion in the rated officer's personnel file, which is referenced for all promotion and reassignment considerations (Department of the Army 2007d, 33-34).

In concept, the evaluation reporting system contributes to the improved performance and professional development of the rated officer, and in turn, the Army as a whole. Over an officer's career, the Army will develop a "whole file" on the officer, establishing a pattern of skills, knowledge, and behaviors from which personnel management decisions can be made with a high degree of certainty as to the appropriateness of an officer for a given position (Department of the Army 2007d, 4).

This system, however, is flawed. Three West Point faculty members note that the current OER "does not do enough to distinguish between officers who possess or lack the [leadership] competencies . . . for the Army of the future" (Boroff, Donigian, and Mundell 2011). There is no standardized metric against which to compare an officer. The rated officer, or the Army, has no way to know if he has developed to the level at which he is expected to be. Furthermore, even if such a metric existed, a 2000 focus group of officers indicated that they never received the requisite counseling necessary to adequately develop and fully understand their duties and responsibilities, or the objectives of their rater and senior rater (Williams, M. 2001, 29-36). The document, as well intentioned as it may be, serves only to describe the rated officer according to the ability of the rater and senior rater. And the senior rater, who must identify the rated officer as "above center of mass," "center of mass," or "below center of mass" (Department of the Army 2007d, 25) has no way of comparing an officer against the hundreds of other officers in the Army.

The novelty of the movement towards a concentration on the development of adaptive leaders makes it even more difficult to interpret the officer evaluation and ensure that the Army is building the adaptive leaders necessary for tomorrow's operating environment. Former Secretary of Defense Robert Gates recognized, before his retirement, that a more effective evaluation of officers is necessary to position the military for the adaptive challenges of the future. Additionally, in his February 2011 speech at West Point, Secretary Gates encouraged Army leaders to consider a "merit-based" or "individualized approach" to the development and evaluation of officers (Boroff, Donigian, and Mundell 2011). Such changes are more likely to ensure the

development and retention of the adaptive, agile leaders necessary to lead the Army in the future operating environment.

Perhaps in recognition of the limitations of the OER, or in response to the comments by Secretary Gates, the Army in September 2011 ordered that all officers complete a 360-degree Multisource Assessment and Feedback (360-MSAF) tool at least once every three years (McHugh 2011). The tool

> is designed to enhance leader adaptability and self-awareness and to identify Army Leaders strengths and developmental needs. Assessments are made by the leader and from those who surround the leader: subordinates, peers, and superiors. The 360-degree assessment builds on the Army standard practice of conducting after action reviews for units. MSAF will provide all army leaders information that will benefit them in current and future leadership positions. It requires candid and honest assessment by those asked to participate in the process. Leaders who have been assessed must expend serious effort to understand their feedback and work diligently to use it for their continued development and for the good of the Army. (Department of the Army 2011c)

The 360-MSAF is a useful tool to help leaders identify skill deficiencies and strengths that may have gone unnoticed previously (Steele 2011, 31).

One portion of the feedback tool, called the I-Adapt, provides the rated leader feedback on seven different dimensions of adaptability (crisis situations; cultural adaptability; work stress; interpersonal adaptability; learning new tasks; technologies and procedures; creative problem solving; and uncertain and predicable work situations). A second portion of the tool, called Team Personality, provides the rated officer information on his leadership abilities and team building. Those measured attributes include tough mindedness, resourcefulness, intellectual capacity, leadership motivation, achievement-seeking, interpersonal tact, teamwork, and trust. A final portion of the tool, called the Leadership Behavior Scale, provides the rated officer information on his leadership competencies (as they are defined in Field Manual 6-22). Those attributes are: leads

others, leads by example, creates a positive environment, communicate, develop leaders, prepare self to lead, get results, extend influence beyond chain of command, and organizational leadership (Department of the Army 2011c). Feedback for each of these attributes provides the leader an awareness of the perception of his leadership skills, knowledge, and behaviors by those who surround him. As such, those leaders who may have previously found it difficult to accept negative feedback from others (some may term these individuals as toxic) may find it more difficult to be dismissive of the data from the 360-MSAF (Steele 2011, 31).

The 360-MSAF is not a new tool for the Army. It began as a two-year pilot study in February 2004 (Department of the Army 2009b). As a human resources and evaluation tool, however, the concept of a 360-degree assessment has been widely used to gauge the efficacy of leadership in the civilian business sector for years (Tyson and Ward 2004). After considering the implementation of the tool in the Army, the results of Army 360-MSAF pilot study revealed that 97 percent of participants believed the program was worthwhile (Department of the Army 2009b). Additionally, more than five years after the 360-MSAF was implemented, 89 percent of the respondents to the 2011 CASAL study indicated that they believed the 360-MSAF provided at least a small positive impact on their leadership development (Riley et al. 2011, 64). Such results must have demonstrated to senior Army leaders that the tool was effective at increasing a leaders awareness of his leadership qualities and the expectations of those soldiers (junior and senior to him). Originally, the 360-MSAF was not intended to be a part of the formal officer evaluation (Department of the Army 2011c) but, in September 2011, the Secretary of the Army

ordered that an officer's completion of the 360-MSAF tool be annotated on his OER (McHugh 2011).

Though the actual 360-MSAF data will not be included in the OER, the acknowledgement of an officer's completion of the tool places a Department of the Army-level emphasis an officer's awareness of potentially hidden weaknesses in his performance, and begins a process of individualizing the OER as Secretary Gates recommended (Boroff, Donigian, and Mundell 2011). The 360-MSAF may not go far enough, however, in helping to develop adaptive leaders for the Army. To internalize and make permanent the lessons of self-awareness, rated officers need to receive counseling, coaching, and mentoring from their senior leaders after receiving the 360-MSAF feedback. It is this pairing that will truly develop Army officers into adaptive leaders.

Leader Assessment in the Army Nurse Corps

In addition to the methods outlined above, Army Nurses are evaluated in a number of other ways. Beginning in 2002, the Practice Environment Scale of the Nursing Work Index (PES-NWI) was implemented throughout the ANC to conduct a system-wide analysis of nursing practice environments. The study established that poor work environments are correlated with poor registered nurse outcomes and quality care (Patrician, Shang, and Lake 2010). The PES-NWI was derived from the Nursing Work Index, a survey scale originally designed to aide researchers in determining a hospital's level of congruence with the findings of the 1983 magnet research study (Kramer and Schmalenberg 2005; Lundmark 2008). Assistant Professor of Nursing at the University of Pennsylvania, Eileen Lake, developed the PES-NWI, which reflects the original Nursing Work Index except that data is derived with five subscales (nurse participation in hospital

affairs; nursing foundations for quality care; nurse manager ability, leadership, and support; staffing and resource adequacy; and collegial nurse-physician relationships) and one composite scale rating (Lake 2002; Lundmark 2008). Since the completion of the 2002 study, the ANC has used the PES-NWI somewhat irregularly to gauge the nursing practice environments at individual Army hospitals. And, though it does not directly reflect the leadership competencies of a single Army Nurse, the results of the PES-NWI, particularly the nurse manager ability, leadership and support subscale, can be used to provide generalized feedback for a particular nursing unit or an entire organization. That feedback reflects the leadership competencies of the leaders of those organizations (the individual unit or the hospital).

In response to the gap analysis completed by senior ANC leaders in preparation for the publication of the 2009 *ANC Campaign Plan*, ANC established the Warrior Care Imperative Action Team, which was in turn tasked to address two specific aspects of the newly formed PCTS framework. The team was asked to develop a plan for providing peer feedback among junior Army Nurses and the civilians with whom the Army Nurses work. Considered a necessary part of professional development for nurses, peer feedback is a systematic review of a nurse by one's peers based on a set of objective, professional standards and criteria (Vuorinen, Tarkka, and Meretoja 2000). Peer feedback is such an important part of the professional development of nurses that the presence of a peer feedback process has been implemented into the magnet status criteria of the American Nurses Association (American Nurses Association 2010). In the ANC, "Peer feedback is an objective and confidential process that allows all licensed members of the Army Nursing team – registered nurses and licensed practical/vocational nurses – to reflect on

their practice and develop professionally through feedback from colleagues on strengths and opportunities for growth" (Prue-Owens, Watkins, and Wolgast 2011). When considered in conjunction with the quarterly counseling the Army Nurse is to receive from his rater, the implementation of Army Nursing Peer Feedback provides each nurse with an additional form of feedback, providing the individual Army Nurse with multiple opportunities for growth, promoting "professional leadership and autonomy" (Hotko and Van Dyke 1998).

Successful implementation of the anonymous peer feedback program gives the senior Army Nurse another perspective when conducting the regular counseling with the junior Army Nurse. Additionally, the consistent use of the standardized peer feedback tool provides a yardstick "against which to measure professional growth and to plan for development" (Prue-Owens, Watkins, and Wolgast 2011). Peer feedback provides the rated officer an objective reference against which to judge his professional development (Bonnel and Boehm 2011; Hotko and Van Dyke 1998; Prue-Owens, Watkins, and Wolgast 2011). When considered with the LCM, quarterly counseling sessions with the Army Nurse's rater provides the opportunity for the junior officer to self-reflect and develop a plan for further personal and professional development.

Summary

The operational environment of tomorrow requires adaptive leaders in the Army and in the ANC. The current Army relies on a leader development system that rewards "reactive thought instead of proactive thought, compliance instead of creativity, and adherence instead of audacity" (Wong 2002). Emphasizing the continued need for an evolution of the government and the military, President Obama stated in the 2012 release

of the Defense Strategic Guidance that "Going forward, we will also remember the lessons of history and avoid repeating the mistakes of the past when our military was left ill-prepared for the future . . . we will ensure that our military is agile, flexible, and ready for the full range of contingencies" (Department of Defense 2012). Preparation for future threats requires adaptive leadership, which produces positive change by facilitating debate, encouraging rethinking, and applying processes of social learning (Cojocar 2009). The ANC, as naturally adaptive professionals, will spearhead the AMEDD effort to develop its leaders to adaptive, agile thinkers.

This review of literature established the need for changes in the way junior Army Nurse leaders are developed. The author nested leader development within the United States *National Security Strategy,* defined adaptive leadership, performed a center of gravity analysis on the ANC, described the negative impact of a cycle of poor leadership, and referenced quantitative data that established leader development weaknesses in the Army and the AMEDD. The author also presented answers to the secondary research questions by describing the current leader development process in the Army and the ANC, then describing how the efficacy of leader development is measured in the Army and the ANC.

In the following chapter, the author recommends the use of the LCM-based counseling tool for use in guiding the development of adaptive junior ANC leaders. Recognizing that the institutional and operational development domains are irreplaceable in the leadership development of ANC officers, the author demonstrates why they are not enough to effectively develop adaptive leaders. Prior to describing the LCM-based counseling tool in detail, the author first introduces the LCM and then links the skills,

knowledge, and behaviors annotated on the LCM to the leader assessment tools identified in the literature review. The LCM-based counseling tool, which integrates these links into a practical format, provides the senior ANC officer a guide to developing his junior officers in a manner that will produce adaptive junior Army Nurses. As clinical and administrative leaders in the AMEDD, Army Nurses developed using the LCM-based counseling tool will be the adaptive officers of tomorrow's Army.

CHAPTER 4

DATA FINDINGS AND ANALYSIS

Introduction

> Nursing is a holistic profession; similarly, nursing leadership should also be holistic, dynamic, inclusive, flexible, and adaptable.
>
> – Janet P. Jackson, Paul T. Clements, Jennifer B. Averill, and Kathie Zimbro, *Patterns of Knowing*

Continued multimodal development is the key to building adaptive leaders. Admiral Thad Allen, the 23rd Commandant of the Coast Guard, noted that the "continual challenge of adaptation and evolution is only met through learning" (2011). Learning, in all environments and methods, must be challenging and envelope-pushing. Leadership educator Donald Vandergriff supported this as well, stating "Schooling must take students out of their 'comfort zones.'" He went on to re-focus those who venture to determine a path for leader development, however, when he noted that, "Those leaders who successfully pass through the schools must continue to be developed by their commanders; learning cannot stop at the schoolhouse door" (2008). Institutional education by itself will not develop adaptive, agile leaders. Operational assignments provide the leader opportunities to put into practice the knowledge gained through his institutional experience. These alone, however, will not produce the adaptive, agile leader needed in the ANC.

Leader development is, first and foremost, a deliberate process that requires a senior leader to actively engage a junior leader, ensuring he develops the skills, knowledge, and behaviors necessary to lead at increasing levels of responsibility and authority. In the ANC, developing the junior leader is increasingly important because a

2008 Center for Army Leadership report notes that morale in the ANC is low and the need for Army Nurses continues to increase, stretching the already thinning ANC even more (Center for Army Leadership 2008, 2.21). Considering the growing stress on the ANC, Colonel Susanne Clark, the Assistant Chief of the ANC, defined leader development as "a persistent, sustainable nurse leader succession plan creating full-spectrum leaders who are adaptive to any conditions based missions, provide persuasive voices at key echelons of influence in the AMEDD, and develop innovative doctrine to blueprint the future of the [ANC]" (Clark and Brewer 2011). The ANC must develop leaders that can take on the challenges of future Army missions. Colonel Clark noted that to fulfill the Army mission requirements, the ANC leader must be adaptive to the situations in which he may find himself. Developing into this adaptive leader, however, poses a challenge to the ANC.

To more effectively develop the adaptive leaders necessary to meet the challenge facing the ANC, Major General Horoho and her staff established imperative action teams to work on four strategic objectives as a part of the *ANC Campaign Plan* (Clark and Brewer 2011). One of these teams, identified as the proponent for the "leader development" objective, was established to study the development of full-spectrum leaders and position the ANC to provide the Army with Army Nurses who are prepared to adaptively lead throughout the organization (Clark and Brewer 2011; Funari, Ford, and Shoneboom 2011). The ANC Leadership Imperative Action Team, established by Major General Horoho, then studied leadership development in nursing and produced a list of competencies necessary for nursing leaders at various levels of responsibility to be successful. This work resulted in the later development of the Army Nursing Leader

Academy, a virtual academic structure designed to address the formal educational needs of Army Nurses according to the professional competencies identified by the ANC Leadership Imperative Action Team. These competencies, and the educational offerings of the Army Nursing Leader Academy and the other institutional educational programs of the Army, were integrated into the LCM (Dunemn et al. 2011; Funari, Ford, and Schoneboom 2011). In this chapter, the author first explains why institutional and operational experiences fail to produce adaptive Army Nurses. He then presents the LCM-based counseling tool, which is designed to serve as a counseling guide for the senior Army Nurse as he deliberately prepares the junior Army Nurse for future levels of responsibility and authority. Finally, the author proposes a method of capitalizing on the institutional and operational experiences of the Army Nurse through a fully integrated process of LCM-based counseling.

Institutional and Operational Development Are Not Enough

Institutional education and operational assignments are the bedrock on which the entire Army leadership development process is founded. They are two domains of the trio described in Army regulation as the Army Training and Leader Development Model (Department of the Army 2009a, 4-5). There is no doubt that, without the experience and exposure of one's institutional education and operational assignments, becoming the adaptive and agile leader necessary to lead in the operational environment of tomorrow is nearly impossible. The self-development domain, however, is paramount to becoming the leader needed in the Army of the future. Self-development, guided by a deliberate process of counseling, mentoring, and coaching, conceptualizes the skills, knowledge, and behaviors a leader gains in the institutional and operational domains and reinforces

the attributes best suited to lead Army Nurses in the operational environments of the future.

The institutional domain, specifically, is unable to fully prepare Army leaders to become adaptive and agile leaders. Current Army officers recognize the importance of institutional education but also recognize that more is needed to best prepare for their increasing levels of responsibility. As noted in chapter 3, recent statistical data from the Army-sponsored CASAL studies provide Army leader development strategists a significant level of insight into the perceptions of Army leaders during a given year. The most recent study, captured in 2010, indicated that Army leaders in general believe that institutional educational experiences are the least effective in preparing leaders to assume new levels of leadership and responsibility (Riley et al. 2011). Additionally, from 2005 to 2010, Army leaders have indicated that their professional military education does not positively impact their leader development (Hatfield et al. 2011).

The institutional domain of ANC leadership development appears to suffer a similar fate. The first-line Army Nurse leader, in most cases, is the Clinical Nurse Officer in Charge, or CNOIC. This Army Nurse is generally expected to attend the CNOIC Course, a "tactical level" leadership course for Army Nurses assigned to the position that is designed to prepare the junior Army Nurse to function as a leader and supervisor at this level (Dunemn et al. 2011). A 2003 study of 23 Army hospitals indicated that Army nursing staff members are generally unsatisfied with the abilities of their first-line Army Nurse leader (Patrician, Shang, and Lake 2010). While the CNOIC Course was being revised at the time of publication of the Patrician, Shang, and Lake study, even major revisions to the course curriculum are unlikely to have a major impact on the leader

development of “tactical level” Army Nurse leaders. The AMEDD and the ANC struggle to prepare its leaders for positions of responsibility as assignments change. In a culture so focused on the constant mission of conducting patient care, senior AMEDD leaders find it difficult to release junior leaders for the appropriate level of leadership development training. The 2008 Center for Army Leadership study on leader development within the AMEDD noted that many AMEDD leaders are “placed in a position of leadership prior to attending the course that would have prepared them for their current assignment” (Center for Army Leadership 2008, 2.3; Bolton 2010, 40). Army Nurses cannot take advantage of the institutional domain of leader development when they are not given the opportunity to attend such training. The twenty-four-hour nature of the AMEDD mission complicates this challenge.

The operational domain of leader development is the leader’s chance to put his newly gained institutional skills, knowledge, and behaviors into practice. Simply assigning an officer to various positions throughout the Army, thereby exposing him to various scenarios and circumstances, increases the officer’s experiential frame of reference and provides him a more broad background on which to base his judgment. The officer’s experiences in the operational assignment combined with personal self development will not produce the adaptive, agile leader, however. The officer’s superiors must develop him appropriately. In the operational domain, leaders enhance the development of their subordinate leaders by

> assigning the individual progressively more complex and demanding duties; assessing [the officer’s] performance against standards, and providing feedback information on strengths, weaknesses, and developmental needs; counseling and coaching regularly; and helping [the officer] prepare and execute developmental action plans to achieve maximum growth. (Department of the Army 1994, 3)

It is the leadership feedback and guided self-development, built on a relationship of trust with his superior(s), within the operational assignment that Army officers consider to be the most effective method of leadership development (Hatfield et al. 2011). The Army Profession Junior Leaders Forum supported this assertion as well, noting that engaged, face-to-face interaction with one's supervisor is more desired and more effective in developing the junior leader than most other leadership development experiences (Tan 2011).

As important as individual leader development is to the Army, it seems that Army leaders are not well prepared to develop their subordinate leaders. In the 2010 CASAL study, 41 percent of all Army leaders indicated that their superiors were ineffective in providing leadership development opportunities to the subordinate leaders they are charged to develop (Riley et al. 2011). The supervising officer is obligated to mentor, coach, and counsel those subordinates placed under his charge. Unfortunately, the supervisor is typically more interested in mission accomplishment than developing the subordinate for future assignments (Lackey and Kamena 2010). Such is often the case in the AMEDD. Two-thirds of Army Nurses believe that their greatest leader development experiences come from broadening assignments outside of the AMEDD, learning from peers, and from guided self-development (mentoring, coaching, and counseling) (Center for Army Leadership 2011). Unfortunately,

> The unique nature of the AMEDD patient care mission combined with the need to maintain the highest proficiency in individual healthcare provider skills results in less time and opportunity for experiences that develop broader leader development skill . . . [Development] is prioritized toward developing, maintaining, and improving clinical skills proficiency rather than general management and leadership skills. (Center for Army Leadership 2008, 2.1-2.2)

It is precisely this reality that necessitates quality counseling, coaching, and mentoring – guided self-development – among Army Nurses today. The other domains of leader development do not have the needed effect that other Army branch officers may receive due to the unique mission of the AMEDD. Assignments outside of the AMEDD are minimally available for Army Nurses. Senior Army Nurses, then, must help the junior Army Nurse to capitalize on the few experiences available to him.

Today's Army healthcare environment calls for supervisors who have the ability and desire to develop their staff. These leaders provide their subordinates with day-to-day coaching and two-way communication, as well as opportunities to practice their own leadership skills while being coached on how to improve (Riley et al. 2011). Senior Army Nurses who create a supportive climate where individual differences are recognized, two-way communication is promoted, and effective listening skills are valued (McGuire and Kennerly 2006) provide the junior Army Nurse an environment that is ripe for learning and self-reflection. It is in this environment that the LCM-based counseling tool will most effectively aide in the development of adaptive, agile Army Nurses.

LCM-based Counseling Tool

In an article in the *Washington Post*, Admiral Thad Allen, the 23rd Commandant of the Coast Guard, noted that "we need to create unity of effort to solve complex problems . . . and we must continually seek the personal skills and tools that enhance our ability to do that" (2011). Such efforts require the junior officer be developed in a manner that prepares him to learn and grow throughout his career. The development of junior officers in the Army has long been documented on Department of the Army Form 67-9-1, the Officer Evaluation Report Support Form, and/or Department of the Army Form 67-9-

1a, the Officer Developmental Support Form (Department of the Army 2007d). Anecdotally, these forms were seldom viewed as tools that could be used with some level of practicality to actively engage the junior officer in his own development. These forms were shortsighted, designed to engage the junior officer over a single year and ignoring the longer-term development of the rated officer. In September 2011, Secretary of the Army John M. McHugh vacated the requirement to use these forms, opening the door for Army leaders to document their counseling, coaching, and mentoring sessions in a way that provides active involvement by the junior and the senior officer. It is under this premise that the LCM-based counseling tool has been developed.

The tool is designed for use as a counseling, coaching, and mentoring worksheet that allows both parties to interact openly and honestly while providing feedback to the junior Army Nurse. The tool should enable the "art and practice of inspiring, energizing, and facilitating the performance, learning, and development of [the junior leader] . . . [the] goal is to guide vision, urge excellence, and empower" (Dunemn et al. 2011). Army Nurses who deliberately use the LCM-based counseling tool to guide their regular counseling, coaching, and mentoring sessions with their subordinate Army Nurses will find their sessions to be more focused, productive, and empowering.

The Leadership Capabilities Map

The LCM-based counseling tool is centered on a document that was established only recently by the Army Nurse Corps. As noted earlier, the LCM is the result of collaboration among senior ANC leaders that began with the development of the *ANC Campaign Plan* and the establishment of the leadership imperative action team (Clark and Brewer 2011; Funari, Ford, and Schoneboom 2011). The imperative action team

"transformed the previous linear approach to developing and progressing leader levels (based on schools attended, promotions received, and positions held) to progression focused on the achievement of expected skills, knowledge, and behaviors" or, a progression based on capability development (Funari, Ford, and Schoneboom 2011). Capability development, the new document infers, results in Army Nurses prepared to lead at all levels of the AMEDD and in a variety of operating environments.

Notice the emphasis on capability development. The LCM is capabilities based, not competencies based. Use of the terms competency and capability may cause some confusion. Is there a difference? Often, the terms are used interchangeably when discussing business processes and personnel development (Leonard-Barton 1992; Finch-Lees, Mabey, and Liefooghe 2005). The ANC uses the term capability over competency, though, as the LCM uses the American Organization of Nurse Executive core leadership nurse executive competencies, labeling them as capabilities instead (Funari 2011). Many who differentiate between capabilities and competencies indicate that competencies are a more narrow set of skills that are technical or professionally specific in nature. Capabilities, on the other hand, tend to reflect the broader attributes of maturity, agility, and adaptability (Stalk, Evans, and Shulman 1992; Marino 1996; Davis and Hase 1999; Conger and Ready 2004; Smallwood and Panowyk 2005; Kochikar and Ravindra 2007; Gardner et al. 2008; Smith 2008). Being a capable person does not mean one has a higher level of competence; rather, "capable people are able to use competencies in novel and complex situations" (Gardner et al. 2008). To accurately reflect the adaptive nature of its future leaders, the ANC deliberately chose to replace the term competency with capability in the LCM.

The LCM longitudinally presents one of the Association of Nurse Executive core executive domains (leadership), which is divided into individual competencies. The competencies (foundational thinking skills, personal journey disciplines, the ability to use systems thinking, succession planning, and change management) are further defined within the three distinct levels of Army leadership – tactical, operational, and strategic leadership.

Army Nurses remain tactical leaders, according to the LCM, until sometime after reaching the rank of major. Up to this point in his career, the Army Nurse develops various skills (or, competencies) primarily related to patient care, through various clinical assignments. Some Army Nurses are also given the opportunity to expand their list of competencies through broadening assignments, which are generally outside of the Army Medical Department and outside of the clinical setting. These various operational assignments provide the Army Nurse an opportunity to grow, expanding his knowledge and behaviors (or, capabilities) beyond those developed in the hospital environment. Eventually, as a senior captain or junior major, Army Nurses are placed in a direct leadership position, the CNOIC. Considered a key developmental assignment for Army Nurses, this is the first test of the officer's leadership capabilities. Until the officer serves in a position of leadership over a clinical staff, the Army Nurse will not be assigned to positions of operational leadership.

Sometime after the completion of an Army Nurse's direct leadership experience, he will begin to receive assignments that place the officer in positions of operational leadership. According to the LCM, these positions may begin as a major and may continue until the officer reaches the rank of senior lieutenant colonel or junior colonel.

At this level of leadership, the Army Nurse may be assigned as a clinical supervisor for multiple clinical units within a hospital, as the director of a clinical training program, or as a staff officer in various organizations throughout the Army. Army Nurses who hold the rank of colonel are assigned to positions of strategic leadership, which may include the chief nurse or commander of an Army hospital.

In its current form, this method of progressive assignments seems to follow the linear ANC Lifecycle Model noted by Funari, Ford, and Schoneboom (2011). At this time, no standard method of communicating an Army Nurse's progression through the capabilities of the LCM exists. As such, U.S. Army Human Resources Command personnel rely on the assumption that an Army Nurse will acquire certain *competencies* during a specific assignment. The officer's successful completion of the assignment is communicated through the annual OER, and no mention of leadership *capability* development is required. Human Resources Command and the ANC are already beginning to shift away from this method of talent management, however, and integrate the LCM into the assignments process for Army Nurses. In the future, an Army Nurse's "rater and senior rater will provide direct input [on the rated officer's] skills, knowledge, and behaviors (SKB) in order to identify not only future potential, but also capability gaps" that need to be filled before the rated officer is a match for an assignment (Nagra 2011). The new talent management method will match Army Nurses (and their capabilities) with the capabilities appropriate for the position. Army Nurses who are more capable will be assigned to the positions requiring the greatest level of capability (Nagra 2011).

Since its inception, the LCM has been integrated into the BOLC training provided to newly commissioned Army Nurses. The junior officers are taught that the LCM is intended for use as a coaching and evaluation tool but can also be used as a self-development tool. The interactive version of the LCM, which is available to all Army Nurses through a restricted-access Army web portal (Army Nurse Corps 2011), allows the Army Nurse to explore the capabilities required by the ANC at the various stages in their career. Each of the five leadership capabilities is linked to a number of capability objectives that are directly related to the level of leadership required of the Army Nurse (tactical, operational, or strategic). With the interactive tool, the Army Nurse can select a specific capability objective and identify several measurable goals that are nested within the capability objectives (see tables 1 through 5, which represent the measurable goals available to Army Nurses at the tactical level of leadership). Similar to the nesting concepts of Army strategy, the underlying assumption of the LCM nesting is that the achievement of these measureable goals equates to the development of the capability objective, and therefore the leadership capability, needed to be a successful, adaptive ANC leader at that specific level of rank and position. In keeping with this assumption, the LCM-based counseling tool is focused on directing the Army Nurse towards the accomplishment of these measurable goals, and therefore, becoming more adaptive.

Table 1. Foundational thinking capability of the LCM for tactical-level Army Nurses

Leader Capabilty	Leader Capability Objectives	Leader Capability Measurable Goals
Foundational Thinking		
	Executes the Vision	
		Understand command and unit mission and vision
		Incorporate the vision into clinical practice
		Demonstrate ability to articulate specific job functions that support mission and vision
		Express respect and care for patients, peers, and colleagues
		Guided by core values of organization
		Deliver Patient Family Centered Care
	Demonstrates unit level evidence-based decision making	
		Incorporate patient and family concerns into decision-making process
		Regularly read professional journal articles to improve clinical practice
		Eagerly identify opportunities to learn
	Develops and expresses self-awareness	
		Develop internal standards, ethics, and values
		Evaluate internal standards, ethics, and values in comparison to external expressions
		Compare internal standards, ethics, and values to peers and is able to identify favorable and unfavorable attributes in self and others

Source: Adapted from Army Nurse Corps, *Army Nurse Corps Campaign Plan*, http://armynursecorps.amedd.army.mil/campaign/campaignplanonwebpagemarch09.pdf (accessed 24 August 2011).

Table 2. Personal journey disciplines capability of the LCM for tactical-level Army Nurses

Leader Capabilty	Leader Capability Objectives	Leader Capability Measurable Goals
Personal Journey Disciplines		
	Seeks direct feedback and adjusts accordingly	
		Meet quarterly with your immediate supervisor to discuss job expectations and performance
		Set goals for yourself in response to feedback regarding job performance and officership
		Use feedback from superiors, peers, and subordinates to better understand your role (role clarity) and improve your performance
	Applies new knowledge at work	
		Read journal articles and attend inservices monthly
		Research unfamiliar diagnoses/meds on assigned patients and utilize the information in developing the plan of care
		Change practice as a result of knowledge gained through reading, CEU presentations, conferences, etc
		Use evidence derived from performance improvement and other nursing metrics to improve care delivery
	Learns from setback and failures as well as successes	
		Maintain focus and momentum despite temporary problems and setbacks
		Apply reason to a setback or mistake to set yourself up to learn something for the experience
		Recognize that problems, setbacks, mistakes and losses are all a part of life
	Sets initial personal, professional, and career goals	
		Established short, intermediate and long range goals and shared them with your rating chain
		Actively pursue experiences in other care environments to develop and validate your goals
		Identify the training, education, and experience required to reach your long term goals
		Have you taken Graduate Record Exam for preparation to attend LTHET?
		Are your personal and professional goals complimentary?
		Consider personal goals when establishing your timeline for achieving professional goals
		Have goals and interests outside of work
	Identifies positive role models and seeks advice	
		Identify colleagues or senior staff on your unit/section that you respect or admire
		Discover what traits they exhibit that you would like to emulate
		Utilize experienced staff members/supervisors in your work area to help you learn and improve as a clinician/officer/leader

Source: Adapted from Army Nurse Corps, *Army Nurse Corps Campaign Plan*, http://armynursecorps.amedd.army.mil/campaign/campaignplanonwebpagemarch09.pdf (accessed 24 August 2011).

Table 3. Systems thinking capability of the LCM for tactical-level Army Nurses

Leader Capabilty	Leader Capability Objectives	Leader Capability Measurable Goals
Systems Thinking		
	Understands unit level processes and the inter-relatedness of inter-disciplinary roles, functions, and responsibilities	
		Share and communication information effectively
		Involve other disciplines in your plan of care for patients
		Able to anticipate the needs of your patients
		Introduce new concepts into the patient care plan
		Plan for complex and unforeseen effects/outcomes
		Incorporate visual cues when educating patients about their disease/condition
	Expresses and builds concerns for unit's success	
		Contribute to creating a positive work environment
		Strive to be part of the solution
		Actively involved in unit and hospital committees
		Contribute innovative ideas/suggestions at staff/department meetings
		Advocate for the advancement of care delivery services
	Understands unit goals in concert with the Commander's lines of effort	
		Know the commander's mission and vision
		Incorporate the mission and vision into daily work
	Responds to divergent inputs and chooses best practices	
		Solicit feedback from patients, peers, and supervisors
		Incorporate feedback into your practice
		Look for best practices and apply them at work
		Involve yourself in research

Source: Adapted from Army Nurse Corps, *Army Nurse Corps Campaign Plan*, http://armynursecorps.amedd.army.mil/campaign/campaignplanonwebpagemarch09.pdf (accessed 24 August 2011).

Table 4. Succession planning capability of the LCM for tactical-level Army Nurses

Leader Capabilty	Leader Capability Objectives	Leader Capability Measurable Goals
Succession Planning		
	Self motivated and motivates others	
		Involved with clinical or leadership committees
		Provide quarterly coaching/counseling sessions to your subordinates that are candid, individualized, and meaningful
		Write objective and candid OERs
		Facilitate opportunities for growth and leadership for your subordinates
		Challenge yourself to reach potential
	Develops a succession plan for own position	
		Develop continuity book for own position
		Groom top performers for integral parts of position to provide a seamless transition of new leadership and ensure adequate support
	Prepares self for next leadership level	
		Attend appropriate developmental courses to prepare for the next leader level
		Lead clinical teams as team leader or Charge Nurse; sponsor new officers and precept new nurses
		Contribute to or lead evidence-based practice or performance improvement projects
		Present clinical lectures and/or poster presentations to colleagues
		Gain experience in the TO&E environment through deployment, field exercises, or training
	Identifies and develops talent in staff	
		Coach subordinates and peers as they lead committees and short-term projects with short end states
		Know assigned staff (i.e., goals, passions, and talents)
		Facilitate growth or identified talent

Source: Adapted from Army Nurse Corps, *Army Nurse Corps Campaign Plan*, http://armynursecorps.amedd.army.mil/campaign/campaignplanonwebpagemarch09.pdf (accessed 24 August 2011).

Table 5. Change management capability of the LCM for tactical-level Army Nurses

Leader Capabilty	Leader Capability Objectives	Leader Capability Measurable Goals
Change Management		
	Identifies gaps in unit processes	
		Understand unit business processes and plans
		Incorporate processes and plans into daily activities
		Assess unit processes in relation to the business of the unit
	Utilize evidence based theoretical framework to initiate unit change	
		Incorporate research and network resources to plan and implement change
		Communicate vision and create coalition for change
		Utilize decision making processes and model confidence in decision-making
		Empower team members
	Adapts to changes and contingencies in transforming environments	
		Remain flexible but focused in fluid environment
		Conduct reassessment of achieved metrics/outcomes
	Suggests and is receptive to innovations	
		Generate 'out of the box' thinking and nontraditional ideas, activities, and actions
		Synthesize unit behaviors and outcomes to support success of changes

Source: Adapted from Army Nurse Corps, *Army Nurse Corps Campaign Plan*, http://armynursecorps.amedd.army.mil/campaign/campaignplanonwebpagemarch09.pdf (accessed 24 August 2011).

LCM and Leader Assessment Tools

One of the primary duties of any leader is to conduct an assessment of his organization and people, comparing the data from this assessment to some known standard. The information gained in a thorough assessment helps the leader establish a focused training regimen to that addresses any shortfalls, or gaps, identified during the assessment while accentuating the capability strengths already present. Additionally, these assessments provide leaders a point of reference from which he can gauge progress

as he works to develop the organization, or the people, and achieve his desired end state (Department of the Army 2006, 11.8). After the training and development begins, the leader must conduct regular, periodic re-assessments, which he then compares to the original assessment data. The changes noted during the re-assessment provide the leader with feedback on the progress of the organization, or the people, towards the desired end state.

In the context of the ANC leader development, the LCM has become the known standard against which all Army Nurses are to be compared. Leaders are expected to assess their junior leaders against this standard and devise a developmental strategy to bridge any capability gaps identified. Senior Army Nurses have a handful of tools available for use in conducting this assessment. Army Nurses today are conducting leadership development assessments through the direct, day-to-day observation of his subordinates, using the data derived from the 360-MSAF, from the ANC Peer Feedback Program, and from the results of PES-NWI surveys distributed throughout the ANC. Each of these programs provide objective data that provides the senior Army Nurse a more comprehensive assessment of the junior officer, who in turn guides the junior Army Nurse towards the measurable goals and capability objectives listed on the LCM.

The direct, day-to-day observation of the subordinate Army Nurse is essential to the overall assessment of the officer. Observation allows the senior Army Nurse to gain a personal understanding of the junior officer and his interactions with the other members of the Army team. Observation also provides information on the junior officer's clinical skills and competencies, which indicates the officer's ability to assimilate new knowledge into his daily activities. The senior Army Nurse does not need to deliberately, or overtly,

observe each subordinate on a daily basis. Rather, the senior Army Nurse needs to be visible and aware of all subordinates throughout his daily duties and activities. Information related to his subordinates will come in the form of patient feedback, chart reviews, staff interactions, daily accountability records, and many other sources. To effectively make use of the direct observation method, the senior Army Nurse needs only to take the time to recognize the information he receives from the various sources and reflect on the information (related to each subordinate officer) in relation to the LCM. Observational data (specific situations) may be evidence that a junior Army Nurse has achieved (or, falls short) in one of the measurable goals in the LCM. The senior Army Nurse should document these observations and reference them during counseling sessions to assist the subordinate officer in planning to develop over time.

The 360-MSAF also assists the senior Army Nurse to identify shortcomings in the junior Army Nurse's leadership capabilities. Each officer must use the tool to request feedback from his superiors, peers, and subordinates at least once in a three-year period (Department of the Army 2011c; McHugh 2011). Respondents to an officer's 360-MSAF are asked to provide the officer with constructive feedback on his leadership attributes and competencies, as they are defined in Field Manual 6-22 (Department of the Army 2006).[1] These responses are sanitized to protect the respondent's identity and promote the candid reflection necessary for the targeted officer to fully grow and learn as a leader.

[1]Army Field Manual 6-22 refers to the leadership attributes and behaviors as core competencies. There seems to be little differentiation between competencies and capabilities (as it relates to individuals) in the manual. The term capability is used but only in reference to an organization (capacity and capability building). However, because of the maturity and adaptability necessary to be an Army leader, the term capability (as defined earlier in this chapter) is more appropriate.

The feedback, acquired through responses to Likert-scaled questions, provides the targeted officer with feedback related to his ability to adapt effectively in stressful situations, his leadership and teamwork attributes, and his leadership behaviors (Department of the Army 2011c). The senior Army Nurse, during counseling sessions, should assist the junior Army Nurse to interpret the most recent 360-MSAF feedback received and encourage a period of self-reflection. During this discussion, the senior Army Nurse can then assist the junior Army Nurse to identify his strengths and areas for improvement in relation to the LCM. Appendix E identifies the leadership competencies and behaviors (as defined in Army Field Manual 6-22) that are assessed using the 360-MSAF and matches them with the leadership capabilities and tactical level capability objectives of the LCM.

In addition to the 360-MSAF, Army Nurses receive feedback through the Army Nursing Peer Feedback program. Instituted as a part of the Patient CaringTouch System (PCTS), the Army Nursing Peer Feedback program reflects an American Nurses Association standard of professional practice (Prue-Owens, Watkins, and Wolgast 2011), which advocates a peer review program "by which registered nurses are held accountable for practice that fosters the refinement of one's knowledge, skills, and decision-making at all levels and in all areas of practice" (American Nurses Association 2010). Previously described in chapter 3, the Army Nursing Peer Feedback program is a clinically focused assessment tool available to the senior Army Nurse. In addition to facilitating self-reflection on the part of the assessed junior Army Nurse, this form of assessment provides the senior leader with an additional perspective of the junior leader. Clinical competency, while not an exact component of the LCM, is an indicator of an Army

Nurse's ability to apply new knowledge, accept constructive feedback, and develop self-awareness, which, in turn, are reflective of the foundational thinking and personal journey disciplines capabilities of the LCM. Using the LCM-based counseling tool, the senior Army Nurse integrates the feedback received through the Army Nursing Peer Feedback program into the developmental discussion with the junior Army Nurse. The developmental plan reflected on the LCM-based counseling tool should address any clinical competency concerns either party may have.

Senior Army Nurses may wish to use a less direct approach when assessing the developmental needs of his subordinate leaders. Feedback from the more personalized items previously mentioned may seem to be less objective due to the relative proximity of the assessor to the targeted junior Army Nurse. The PES-NWI, which has been used in Army medical treatment facilities for nearly a decade, provides a more global impression of nursing leadership throughout the organization. The connection between the LCM and the PES-NWI is not one that is based on the presence or absence of capabilities or competencies on the part of the nursing leadership (see Appendix F). The PES-NWI reflects the nursing work environment through the eyes of the clinical nursing staff (Lake 2002). The survey, is implemented at regular intervals AMEDD-wide, reflects the clinical staff nurse's perception of his work environment and accounts for a variety of factors that are not directly related to the leadership capabilities of the nursing leadership. Some of the subscales, however, can be used to indirectly infer the leadership capabilities of the nursing leaders throughout the organization. Nesting the results of the organization-wide feedback allows nursing leaders to then derive developmental needs of leaders throughout the entire organization. If, for example, PES-NWI results demonstrate that the

clinical staff nurse does not perceive the supervisory staff to be supportive of the clinical staff, all supervisory staff members should find in their developmental plan some training that reflects this organization-wide shortcoming.

The Tool

Leadership development in the Army occurs in three domains, institutional education and training, operational assignments, and self-development (Department of the Army 2007a; Department of the Army 2007b; Department of the Army 2007c; Department of the Army 2009a). In the larger Army, the three domains are standardized across all branches in an attempt to provide the same level of training and development to all officers regardless of his career path and experiences. All officers complete similarly structured institutional training and experience similarly patterned operational assignments (i.e., platoon leader, company executive officer, company commander, battalion operations officer/battalion executive officer). The AMEDD officer, and specifically the Army Nurse, does not experience the same level of standardization across his career.

As noted in chapter 3 and earlier in this chapter, Army Nurses do not receive the same amount of institutional training and education as his colleagues in the larger Army. Variety in operational assignments is limited for Army Nurses, as well. For the first seven to ten years of his career, the Army Nurse will find that most assignments are focused on developing his clinical skills (competencies) in preparation for deployment to a combat zone or for clinical leadership positions later in his career. While it is important to develop young nurses clinically, such a narrow professional focus may hinder the young officer's maturation process and the development of his leadership knowledge and

behaviors (capabilities) that allow the officer to adapt to changing conditions in his environment. To bridge the gap between the limited availability of institutional leadership training and operational experiences that prepare the officer to lead, junior Army Nurses must be developed at the lowest level of the organization, through the self-development domain of Army leadership development.

Self-development, by its very nature, places the junior Army Nurse in a position of responsibility over his maturation process. It does not, however, relieve the senior Army Nurse of the responsibility to guide, or facilitate, the junior officer's development (Department of the Army 2009a). The LCM-based counseling tool should be used by the senior Army Nurse to guide the junior leader through a planned, goal-oriented developmental process that expands the depth and breadth of the younger officer's knowledge base. By orienting the developmental processes towards the LCM using this tool, the senior Army Nurse ensures that the junior officer is prepared to lead other AMEDD professionals in the ever-changing operational environment that our nation faces. The LCM-based counseling tool is designed to facilitate a discussion between the junior and senior Army Nurses that identifies the junior officer's developmental needs and strengths. The junior officer remains responsible for actually executing the developmental plan, while the senior officer is responsible for deliberately facilitating the process (rather than just letting it happen).

The LCM-based counseling tool, shown in figures 1 and 2 below, is modeled after the Student Individual Development Plan used by the faculty of the U.S. Army's Command and General Staff College (Department of the Army 2011e). Designed to stimulate the junior Army Nurse's movement towards his personal and professional end

state, the LCM-based counseling tool provides a template for a discussion between the junior and senior Army Nurses. This discussion, if effective, should foster a learning, caring environment in which both officers are ready and willing to experience growth in their personal and professional lives and the junior Army Nurse is empowered to reach his personal and professional end state.

After completing the administrative data (boxes 1 through 12, as appropriate), the two Army Nurses are prompted to discuss the significant duties and responsibilities of the junior officer. This description, which should be recorded in box 13, will then serve as a point of reference for completion of the remaining portions of the tool. After this brief work-related discussion, the pair of Army Nurses should then move into a discussion on the junior officer's personal and professional circumstances, goals, preferences, challenges, and strengths. The senior Army Nurse should learn a great deal about his subordinate at this time. Important information related to this discussion should be annotated in box 14 to serve as a record of those circumstances, goals, preferences, challenges, and strengths that may impact on the junior Army Nurse's ability to work within his duties and responsibilities. At this time, the senior Army Nurse may also want to provide the junior Army Nurse with some initial feedback based on the senior officer's observations of the junior officer prior to the counseling session. Again, this information should be recorded in box 14 so that it may be referenced during future counseling sessions.

After the Army Nurses have come to a common understanding of the junior Army Nurse's duties and responsibilities, as well as his personal and professional circumstances, goals, preferences, challenges, and strengths, the officers can discuss the

junior Army Nurse's long-term end state (defined as five to ten years in the future). This end state may be professionally related (military or non-military in nature) and/or it may be personal. Regardless of the nature of the junior officer's long-term end state, they should be recorded in box 15 of the LCM-based counseling tool. Any part of the end state that is ANC-related should be expressed with some correlation to positions or capabilities presented on the LCM.

The junior Army Nurse's medium-term end state (defined as two to five years in the future), which is to be recorded in box 16, should be nested within the junior officer's long-term end state. In other words, the medium-term end state should support the long-term end state, moving the junior Army Nurse toward his long-term end state (personal or professional). Again, any part of the medium-term end state that is ANC-related should be expressed with some correlation to positions or capabilities presented on the LCM. Next, to assist the junior Army Nurse in reaching his medium-term end state, and prepare him for the accomplishment of his long-term end state, the senior Army Nurse assists the junior officer to decide on medium-term objectives that will move the junior leader towards his medium-term end state. The medium-term objectives, which may be personal or professional in nature, are recorded in box 17 of the LCM-based counseling tool. As the junior Army Nurse considers what objectives might be appropriate for his medium-term end state, the senior Army Nurse should take the time to share his professional and personal experiences with the junior officer (as appropriate). For those goals that are ANC-related, the senior Army Nurse should assist the junior Army Nurse in selecting a number of LCM-based objectives that, once accomplished, will position the junior Army Nurse to reach the medium-term end state he defined in box 16.

On the second page of the LCM-based counseling tool, in box 18, the junior and senior Army Nurses will work together to identify short-term goals (defined as reachable in 0-2 years) that support the accomplishment of the junior Army Nurse's medium-term goals. Based on the medium-term end state and objectives, some of the short-term goals should come from the list of measurable goals provided in the interactive LCM (see tables 1 through 5 earlier in this chapter). Doing so keeps the junior Army Nurse professionally driven and ensures that his professional progression is oriented towards the development of leadership capabilities that will, in turn, result in a more adaptive, flexible Army Nurse. Those medium-term objectives that are accomplished or supported by the short-term goals are then annotated in box 19. Boxes 20 and 21 allow the junior Army Nurse to prioritize each short-term goal and then annotate the accomplishment of each goal as necessary. To ensure clarity in the process of achieving the short-term goals, the junior and senior Army Nurses work together to determine the measure of success for each short-term goal and how the junior Army Nurse will work to achieve that goal. Simply stated, the information placed in box 22 identifies how the accomplishment of the short-term goal will be measured. In box 23, the Army Nurses will annotate how the short-term goals will be accomplished and establish a suspense date for that goal. The suspense date is not meant to be punitive but serves as a method of orienting the pair to time while considering these goals and providing a benchmark for progress toward the accomplishment of the medium-term end state.

The time it takes for the junior and senior Army Nurses to effectively interact and complete this form may be substantial. Doing so may require multiple sessions, after each of which the junior Army Nurse takes time to reflect on each portion of the form before

fully committing to the short-term goals on the second page of the LCM-based counseling tool. Once the Army Nurses agree to the short-term goals on page two, the document serves as a living contract between the two Army Nurses. The junior Army Nurse agrees to work towards the short-term goals honestly and whole-heartedly while the senior Army Nurse agrees to his subordinate in reaching those goals while also holding the junior Army Nurse accountable for his failure to progress towards those goals.

As a living document, the LCM-based counseling tool can (and should) be updated regularly. Over time, the junior and senior Army Nurses will be able to integrate various forms of feedback (from direct observation, self-reflection, peer feedback, the 360-MSAF, or the PES-NWI) into the LCM-based counseling tool. End states, objectives, goals, circumstances, preferences, challenges, and strengths may change after receiving this feedback. Any updates or changes can be annotated in blocks 24, 25, and 26. These blocks serve as a record of the developmental discussions and as a reminder that regularly revisiting the LCM-based counseling tool improves the likelihood of success in achieving the short-term goals. And, perhaps it bears repeating, the successful accomplishment of these nested goals and objectives are likely to result in the successful achievement of the junior Army Nurse's medium and long-term end states.

Army Nurse Corps Leadership Capabilities Map Counseling Tool (Page 1)				
1. Rated Officer (Last, First, MI)	**2. SSN**	3. DOR	**4. Rank**	**5. AOC**
6. Rater (Last, First, MI, Rank)	**7. Senior Rater** (Last, First, MI, Rank)	**8. Organization**		
9. 1st Session (Date and Initials)	**10. 2nd Session (Date and Initials)**	**11. 3rd Session (Date and Initials)**	**12. 4th Session (Date and Initials)**	
13. Description of significant duties and responsibilities:				
14. Record of initial discussion and feedback from initial observations:				
15. LONG TERM (brief description of long-term professional and personal end state -- 5 to 10 years out; Professional end state should correlate to information on Leadership Capabilities Map)				
16. MEDIUM TERM (brief description of medium-term professional and personal end-state -- 2 to 5 years out; Professional end state should correlate to information on Leadership Capabilities Map)				
17. Medium Term Objectives [May come from the Leadership Capabilities Map, according to leader level of position desired in Medium Term End State, block 16, (tatical, operational, strategic)]				
a)	k)			
b)	l)			
c)	m)			
d)	n)			
e)	o)			
f)	p)			
g)	q)			
h)	r)			
i)	s)			
j)	t)			

Figure 1. LCM-based Counseling Tool (Page 1)

Source: Created by the author. Adapted from Department of the Army, *Student Individual Development Plan* (Fort Leavenworth, KS: U.S. Army Command and General Staff College, 2011).

Army Nurse Corps Leadership Capabilities Map Counseling Tool (Page 2)					
18. SHORT TERM (measurable goals, many from the Leadership Capabilities Map interactive tool, aimed to achieve your medium term objectives -- 0 to 2 years out)	**19. Objective(s) Supported**	**20. Priority**	**21. Status**	**22. Measure of Success**	**23. Program** (planned developmental activities and date for expected completion)
24. 2nd Session Feedback Points (information from Supervisor, Peers, 360-MSAF, PES-NWI, or other sources) and Discussion					
25. 3rd Session Feedback Points (information from Supervisor, Peers, 360-MSAF, PES-NWI, or other sources) and Discussion					
26. 4th Session Feedback Points (information from Supervisor, Peers, 360-MSAF, PES-NWI, or other sources) and Discussion					
This form is intended for use in conjunction with the OER Support Form (DA Form 67-9-1) to support short-term, medium-term, and long-term leader development of the Army Nurse. If used in concert with the Army Nurse Corps Leadership Capabilities Map (and the drill down tools), this document can facilitate coaching, mentoring, and counseling on the part of the senior Army Nurse and stimulate the professional growth of the junior Army Nurse, resulting in adaptive ANC leaders for tomorrow's changing operating environment.					

Figure 2. LCM-based Counseling Tool (Page 2)

Source: Created by the author. Adapted from Department of the Army, *Student Individual Development Plan* (Fort Leavenworth, KS: U.S. Army Command and General Staff College, 2011).

Fully Integrated Guided Self-Development

At first glance, one may struggle to understand how use of the LCM-based counseling tool will result in the adaptive, flexible leaders required under the *ANC Campaign Plan*. The tool is modeled after an individual developmental plan that focuses on the accomplishment of personal end states and objectives. How can the ANC reach the end state outlined in the *ANC Campaign Plan* if junior Army Nurses are developed in a manner that is wholly focused on the individual and not the organization? The answer lies in the structured interaction between the junior and senior Army Nurses, which results in guided self-development on the part of the junior Army Nurse. It is this guided self-development that fills the leadership development gaps between an Army Nurse's institutional leadership development and his operational assignments (which are of limited variety).

The LCM-based counseling tool should be a part of a fully integrated, guided self-development program. The term "fully-integrated" refers to the integration of all aspects of Army (and AMEDD) leadership development process into the guided self-development instituted through the use of the LCM-based counseling tool. As the junior and senior Army Nurses conduct their regular counseling, coaching and mentoring sessions, the short-term goals and medium-term objectives must include aspects of institutional education and training as well as the consideration of operational assignments that may be appropriate for the junior Army Nurse's medium- and long-term end states. Senior Army Nurses who effectively use the LCM-based counseling tool enable their efforts to facilitate the development of his subordinate officer while also

placing the responsibility for the execution of the development plan on the junior Army Nurse.

Using the LCM-based counseling tool can benefit both Army Nurses during the course of completing the junior officer's OER, as well. By integrating the LCM-based counseling tool into the regular counseling sessions already required by Army regulations (Department of the Army 2007d), the senior Army Nurse capitalizes on his use of time while also developing a broader spectrum of interaction from which to draw when preparing the junior Army Nurse's annual OER. A greater understanding of the junior Army Nurse and his circumstances, goals, preferences, challenges, and strengths leads to a more accurate OER. Additionally, senior Army Nurses can reflect on the OER the progress of the junior Army Nurses towards higher levels of leadership capability. Such annotations, when viewed by the assignment officers at U.S. Army Human Resources Command, enable a more thorough and insightful assignment process for all stakeholders in the ANC.

To illustrate the use of the LCM-based counseling tool in a clinical nursing environment, consider the following example; an example of a completed LCM-based counseling tool is shown in figures 3 and 4. The senior Army Nurse who is conducting the counseling session is Major Daniel T. Smith. The junior Army Nurse being counseled is First Lieutenant John R. Doe. Both are stationed at the U.S. Army Medical Activity at Fort Polk, Louisiana. It is June 2012, and Major Smith took over the CNOIC position about a month ago. After spending time getting to know his staff and the organization, Major Smith decided to begin his quarterly counseling sessions with his staff members.

On this date, 15 June, First Lieutenant Doe reports to Major Smith's office for the counseling.

After a brief period of pleasantries, Major Smith explains to First Lieutenant Doe that this counseling session is the first of the quarterly sessions they will conduct. During each meeting, the pair will discuss Doe's OER-related job performance and will use the LCM-based counseling tool to guide First Lieutenant Doe's self-development. Major Smith then asks some open-ended questions of First Lieutenant Doe in an attempt to learn more about the young Army Nurse on a professional and personal level. An active listener, Major Smith writes down a few notes throughout the discussion (box 13 of figure 3). After the counseling session, Major Smith will compile his notes and annotate them on the LCM-based counseling form before turning the form over to First Lieutenant Doe for his reference.

After getting to know First Lieutenant Doe a little better, Major Smith orients him to the OER support form (Department of the Army 2007d), the LCM (Dunemn et al. 2011), and the LCM-based counseling tool. First Lieutenant Doe recognizes the LCM from the AMEDD BOLC he attended a couple of years ago. The counseling tool is new to him, however. Major Smith describes the purpose of the tool, which is to help guide the younger Army Nurse through a self-development process that results in a more adaptable, confident, and flexible Army Nurse. The officers discuss First Lieutenant Doe's long-term end state and his medium-term end state (which are annotated in boxes 15 and 16 of the sample in figure 3).

With a better understanding of First Lieutenant Doe's circumstances, goals, preferences, challenges, and strengths, Major Smith helps the younger Army Nurse to

develop some medium-term objectives that support his long- and medium-term end states. Major Smith reminded the junior officer that these objectives are two to five years from achieving. When possible, Major Smith tried to introduce terms from the LCM into First Lieutenant Doe's objectives so that the developmental plan reflected their consideration of the leadership capability needs of the ANC (the grayed portion of box 17 in figure 3). Next, the officers address the short-term goals on the second page of the LCM-based counseling tool. These goals may be achieved within the next two years. Again, Major Smith introduces a few specific and measurable goals from the interactive LCM (Army Nurse Corps 2011) for First Lieutenant Doe's consideration (the gray portion of box 18 in figure 4). Together, the officers develop measures of success, a plan of execution, and a suspense date for each item listed under the short-term goals.

Finally, Major Smith directed First Lieutenant Smith to the OER support form. Major Smith wants the lieutenant to use this form, which only covers a calendar year, to identify very short-term goals that are specific only to his professional work at Fort Polk. Some of these goals may be repeated from the LCM-based counseling tool. Some may be unique to the OER support form. Major Smith explains that both forms will be used to evaluate Doe's performance and potential for growth in the ANC. Major Smith will also use the LCM-based counseling tool to hold First Lieutenant Doe responsible for the developmental tasks (the short-term goals) he agreed to complete. At the end of the session, Major Smith noted that the two officers will sit down again in about three month to check on the lieutenant's progress and to provide further feedback on his performance. At that time, Major Smith may have some data from the Army Nursing Peer Feedback program. Major Smith also instructed First Lieutenant Doe to initiate a 360-MSAF

survey so his peers, subordinates, and superiors can provide him leadership feedback. The survey should be timed so that the feedback will be available in time for the next counseling session. Based on these forms of feedback, the short-term goals may need to be adjusted.

This example highlights the process of conducting fully integrated counseling sessions. The sessions, as described, are not punitive counseling. They are coaching and mentoring sessions. The senior Army Nurse guides the discussion but he is not the focus. The junior Army Nurse is given ownership of his development and understands that he would be held accountable for his efforts to follow his developmental plan. This type of collegial leadership on the part of the senior Army Nurse, through the LCM-based guided self-development, will result in adaptive, confident Army Nurses who will lead in the operating environments of the future.

Army Nurse Corps Leadership Capabilities Map Counseling Tool (Page 1)

1. Rated Officer (Last, First, MI)	2. SSN	3. DOR	4. Rank	5. AOC
Doe, John R.	XXX-XX-1234	15-Feb-11	1LT	66H

6. Rater (Last, First, MI, Rank)	7. Senior Rater (Last, First, MI, Rank)	8. Organization
Smith, Daniel T., MAJ	Jones, Rebecca L., LTC	USAMEDDAC, Fort Polk, LA

9. 1st Session (Date and Initials)	10. 2nd Session (Date and Initials)	11. 3rd Session (Date and Initials)	12. 4th Session (Date and Initials)
15 Jun 12/ JRD, DTS			

13. Description of significant duties and responsibilities:
Clinical staff nurse on a XX-bed medical/surgical ward, in a XX-bed MEDDAC, directing and providing professional nursing care. Functions as charge nurse, supervising 1-4 professional nurses. Uses the nursing process to assess,plan, implement, and evaluate patient care. Coordinates with other disciplines to provide optimal patient care in accordance with department policies and professional standards of practice. Assists the CNOIC with clniical and administrative responsibilities as assigned.

14. Record of initial discussion and feedback from initial observations:
1LT Doe is a motivated young nurse and officer. He is married with no children but would like to start a family soon. He graduated from an ROTC program, on a nursing scholarship, but has no prior military service. He has been with this organization for six months. Since MAJ Smith's arrival to the unit one month ago, 1LT Doe has performed his duties and responsibilities appropriately. Informal feedback indicates that 1LT Doe is well liked and respected among the staff; clinically, no major flaws have been identified.

15. LONG TERM (brief description of long-term professional and personal end state -- 5 to 10 years out; Professional end state should correlate to information on Leadership Capabilities Map)
Professionally, in 5-10 years, 1LT Doe would like to be an Army CRNA. He also would like to be assigned to an airborne forward surgical team. He would also like to position himself to get his PhD and teach in the future. Personally, 1LT Doe would like to develop a stronger relationship with his wife; he would like to have at least one child; and he would like to begin saving money for his child's college fund.

16. MEDIUM TERM (brief description of medium-term professional and personal end-state -- 2 to 5 years out; Professional end state should correlate to information on Leadership Capabilities Map)
Professionally, in 2-5 years, 1LT Doe will most likely be a captain and preparing to increase his level of responsibility in the Army Nurse Corps. He also sees himself beginning the Army CRNA program. Personally, 1LT Doe would sees himself as a more physically fit individual, with at least one child (already here or on the way), and a growing relationship with his wife that he continues to actively foster.

17. Medium Term Objectives [May come from the Leadership Capabilities Map, according to leader level of position desired in Medium Term End State, block 16, (tatical, operational, strategic)]

a) Demonstrates unit-level evidence-based decision making	k) Prepares to participate in half-marathon
b) Develops and expresses awareness	l) Improves relationship with spouse
c) Applies new knowledge at work	m) Uses leave regularly for family vacations
d) Sets intial personal, prof., and career goals	n) Allocates money to savings for college fund
e) Self motivated and motivates others	o)
f) Prepares self for next leadership level	p)
g) Learns from setbacks and failures as well as successes	q)
h) Identifies and develops talent in staff	r)
i) Suggests and is receptive to innovations	s)
j) Adapts to changes and contingencies in transforming environments	t)

Figure 3. Sample LCM-based Counseling Tool (Page 1)
Sources: Created by the author. Adapted from Department of the Army, *Student Individual Development Plan* (Fort Leavenworth, KS: U.S. Army Command and General Staff College, 2011).

Army Nurse Corps Leadership Capabilities Map Counseling Tool (Page 2)					
18. SHORT TERM (measurable goals, many from the Leadership Capabilities Map interactive tool, aimed to achieve your medium term objectives -- 0 to 2 years out)	**19. Objective(s) Supported**	**20. Priority**	**21. Status**	**22. Measure of Success**	**23. Program** (planned developmental activities and date for expected completion)
Evaluates internal standards, ethics and values in comparison to external expressions	a	12		Few expressions of anger or frustration	Daily AAR; Church weekly
Change practice as result of knowledge gained through reading CEU, conference	b, c	7		Expresses implementation of new idea to clinical day	As needed; assessed quarterly
Seeks assignment in an MTF to gain critical care experience	d	5		Assigned to MEDCEN ICU	Contact Branch Manager, fall 2012
Prepare for/take GRE	d	2		GRE scores high enough for CRNA	GRE Study Course, Fall 2012; Exam, Spring 2013
Involved with clinical or leadership committees	e	6		Attends meetings	QA meetings
Attends Critical Care Course	d, f	1		Graduates CCC	BAMC CCC, Spring 2013
Maintains focus and momentum despite temporary setbacks	g	8		Achieves medium term objectives	Regular interaction with CNOIC
Coaches peers as they lead short-term projects	h	11		Serves as preceptor	AN Orientation Program
Generates nontraditional ideas	i	13		Institutes practice change unit wide	As needed; assessed quarterly
Conducts assessment of metrics/outcomes	j	14		Completes this form	Quarterly
Join running club	k	10		APFT run improves	Oct-12
Bi-weekly date night	l	3		Wife enjoys dates	"Date night" book, Fall 2012
Go on three family vacations each year	l, m	4		Leave balance <30	Oct-12
Sets up monthly allotment to college fund	n	9		$100/month saved	Bank College Fund, Aug 2012
24. 2nd Session Feedback Points (information from Supervisor, Peers, 360-MSAF, PES-NWI, or other sources) and Discussion					
25. 3rd Session Feedback Points (information from Supervisor, Peers, 360-MSAF, PES-NWI, or other sources) and Discussion					
26. 4th Session Feedback Points (information from Supervisor, Peers, 360-MSAF, PES-NWI, or other sources) and Discussion					
This form is intended for use in conjunction with the OER Support Form (DA Form 67-9-1) to support short-term, medium-term, and long-term leader development of the Army Nurse. If used in concert with the Army Nurse Corps Leadership Capabilities Map (and the drill down tools), this document can facilitate coaching, mentoring, and counseling on the part of the senior Army Nurse and stimulate the professional growth of the junior Army Nurse, resulting in adaptive ANC leaders for tomorrow's changing operating environment.					

Figure 4. Sample LCM-based Counseling Tool (Page 2)

Sources: Created by the author. Adapted from Department of the Army, *Student Individual Development Plan* (Fort Leavenworth, KS: U.S. Army Command and General Staff College, 2011).

Summary

A 2008 study by the RAND Corporation found that officers yearn to be developed. The same study also found that junior officers seldom felt as though they were being developed. The senior officers queried in the same study noted that they believed they developed their junior leaders very well. The difference, it turns out, was either side's perception of informal discussions and interactions. The junior officers did not believe the informal discussions and interactions to be developmental in nature, while the senior officer believed they were (Schirmer et al. 2008). Who is correct?

Army leadership development, as noted in chapter 3, has long had self-development as one of its tenets. An underlying theme of the leadership literature reviewed in chapter 3 is that leadership development is as much the individual's responsibility as it is the organization's responsibility. Though he was talking specifically about mentoring (a form of leadership development), General Robert W. Cone, the commanding general at TRADOC, implied the same when he stated, "Not everyone deserves a mentor. In order to have a mentor in this profession, you have to have a commitment to excellence in this profession. If you don't have a mentor, look at yourself in the mirror" (Bacon 2011). This senior Army officer placed responsibility for one's leadership development squarely on the shoulders of the individual officer. General Cone's assertion seems to be supported by research groups as well. In a 2006 Rand Corporation study on Army leadership, researchers note that individual leaders "need to engage in continuous learning and to become confident that they can acquire new skills and knowledge quickly when they confront new challenges" (Leonard et al. 2006, 106). It is the junior leader's responsibility, then, to seek professional growth and development.

Those who seek leadership development become actively engaged in their career progression, receive the feedback they need, reflect on their skills, knowledge, and behaviors, and grow into the adaptive leaders required by the changing operating environment.

Such an emphasis on the junior leader's responsibility to manage his own leadership development does not preclude the more senior officers from actively engaging their subordinate leaders. Lieutenant Colonel Leigh McGraw, an Army Nurse, wrote "We have a collective responsibility to mentor and foster the professional growth of our newest team members so they may mentor those who follow" (2011, 9). As noted in chapter 3, Army officers (to include Army Nurses) are duty-bound to develop the junior leaders placed under their purview. A part of this requirement is the expectation that senior leaders conduct formal counseling sessions with their subordinate leaders on a regular basis (Department of the Army 2007d). By formalizing the leader development process, and focusing that developmental process on the junior officer's responsibility to himself, senior Army Nurses who use the LCM-based counseling tool introduced in this chapter will fill the perceived voids in junior Army Nurse leadership development.

In the following chapter, the author concludes this thesis by evaluating the appropriateness of the LCM-based counseling tool, using the evaluation criteria of the military decision-making process, as a means of guiding the junior Army Nurse through the self-development domain of Army leadership development. Furthermore, the author reinforces the use of LCM-based counseling as one of the preferred methods to accomplishing the objectives of the *ANC Campaign Plan* and the importance of developing adaptive Army Nurses for the future operating environment. In an

environment of constrained resources (Department of Defense 2012), capitalizing on leadership development capabilities at the lowest level is paramount. Institutional learning opportunities will decrease, much of it shifting to distributed learning. Decreased funding will thin the already stretched ANC, placing even greater strain on the individual officer. These factors point to the importance of a fully integrated leader development system for the junior Army Nurse, an LCM-based system that promotes the officer's development in spite of the fiscal limitations placed on the future institutional ANC.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

> Leaders lacking adaptability enter all situations in the same manner and often expect their experiences in one job to carry them to the next. Consequently, they may use ill-fitting or outdated strategies. Failure to adapt may result in poor performance in the new environment or outright organizational failure.
>
> – Department of the Army, Field Manual 6-22, *Army Leadership (Competent, Confident, and Agile)*

Introduction

Adaptive leaders are a necessary component of the future United States military strategy. Analysts and strategists postulate that the operating environment that American military leaders will face in the future is one that will shift chaotically, introducing uncertainty into a battlefield that military leaders so ardently attempt to attack systematically. Furthermore, the coming end to more than a decade of conflict will result in a scarcity of resources the likes of which many junior military leaders have never experienced (Department of Defense 2012; Odierno 2012). Reflected in the 2010 *National Security Strategy* (Office of the President of the United States 2010) and subsequent Department of Defense and Department of the Army publications, the potential military reality for the United States requires that military leaders be capable of rapidly developing new skills, acquiring new knowledge, and adjusting their behaviors as the environment changes around them. To properly support the various missions the Army may face in the future, the ANC must continue to focus its efforts on the development of adaptive and agile junior leaders.

As noted in chapter 1, the ANC led the way towards the development of adaptive leaders in the Army, taking the first steps towards adaptive leadership in 2009 with the

publication of the *ANC Campaign Plan*. In doing so, the ANC began an effort to "create full spectrum leaders; who are creative thinkers, intrepid explorers, who can see beyond what is today to shape the future, who are adaptive to any conditions-based mission . . ." (Army Nurse Corps 2009). In codifying this plan, however, the ANC was left with a major question: how should the ANC develop adaptive junior leaders? This thesis sought to answer that question through the use of the LCM-based counseling tool, which was described in chapter 4. In this chapter, the author assesses the use of the LCM-based counseling tool using the evaluation criteria inherent in the Army's military decision-making process before making a final recommendation to the ANC on the development of adaptive junior leaders.

Interpretation of Findings

To answer the primary research question, the author explored the root of the ANC leadership challenges in chapter 3 of this thesis. A review of several national strategy-level documents, to include the *National Security Strategy*, the *National Defense Strategy*, the *National Military Strategy*, and their less formal updates, demonstrated that the Army of the future will find itself operating in environments that are more complex, more chaotic, and more ambiguous that the environments of the American military past. According to these documents, success in such environments requires military leaders who are capable of being adaptive to the environment(s) in which they are required to operate (Office of the President of the United States 2010; Department of Defense 2011c; Department of Defense 2012; Department of the Army 2009b; Department of the Army 2011b; Odierno 2012). Supporting such strategic leadership concerns, Army leadership

training is beginning to evolve, focused on developing leaders who are prepared to lead in the uncertain environments described by our strategic leaders.

TRADOC administers the service's leadership training. To prepare officers for their leadership duties, TRADOC requires a specific, standardized curriculum of leadership in addition to the training required for each officer's military area of concentration. The AMEDD is required to train its leaders in accordance with TRADOC regulations, although some allowance is made for the unique professional status of the AMEDD officer, recognizing that greatest focus for the AMEDD officer is generally on his development of clinical competencies of the profession rather than his leadership education. In recent years, however, two perceived leadership failures within the AMEDD–both of which coincidentally occurred at Walter Reed Army Medical Center in Washington, DC–indicated to Army and Congressional leaders that AMEDD leadership training was substandard. Subsequent studies by the Center for Army Leadership and the AMEDD Center and School demonstrated that leadership training in the AMEDD meets the TRADOC requirements but fails to prepare officers for the duties and responsibilities of leading (Bolton et al. 2011; Center for Army Leadership 2008; Center for Army Leadership 2011; Department of Defense 2010; Hatfield et al. 2011; Kirby et al. 2011; Lieberman and Collins 2011; Riley et al. 2011; Steele 2011).

Adaptive Nurses in the Army

Nurses, by the nature of their profession, are adaptive. Clinical practices and medical technology change frequently, causing nurses to adapt to the new clinical environment. A patient's condition may change suddenly, causing the nurse to adapt his plan of care on a moment's notice. Adaptation is integral to the profession. Army Nurses,

however, are challenged in a way that most other nurses are not. The average Army Nurse finds himself vacillating between the leadership requirements of two different parts of the Army. The clinically oriented AMEDD requires leaders who are capable of leading and operating in the business-like environments of the modern healthcare enterprise. The combat oriented side of the Army requires leaders who are capable of leading and operating in the austere mission environments of the average Army soldier (Center for Army Leadership 2008, 2.10; Leonard 2006). And, while the institutional leadership development required by the Army focuses primarily on leadership skills, knowledge, and behaviors that are combat oriented, Army Nurses spend the vast majority of their time operating in the clinical environment that is the AMEDD healthcare enterprise. The operating environments of the future require Army Nurses to develop capabilities that allow them to thrive in either setting while meeting the mission requirements for both environments.

Appropriateness of the LCM-based Counseling Tool

Chapter 3 demonstrated the linkage between the *National Security Strategy* and the *ANC Campaign Plan*. Essential to the success of the *ANC Campaign Plan* is the development of a "deep bench" of adaptive junior Army Nurses (Clark and Brewer 2011; Funari, Ford, and Schoneboom 2011). Key to the development of these officers is the LCM. Developed by the ANC's Leadership Imperative Action Team, the LCM is designed for use as a coaching and counseling tool for the junior Army Nurse (Funari, Ford, and Schoneboom 2011). The underlying assumption is that using the LCM, the junior Army Nurse is able to tailor his self-development to his developmental needs and become the adaptive Army Nurse required in the *ANC Campaign Plan*. When used in

concert with the normal completion of AMEDD institutional development and operational assignments, LCM-based counseling is likely a viable developmental tool for the junior Army Nurse.

In reviewing this thesis, one might consider the information contained herein as similar to a military decision brief. In a military decision brief, staff officers present courses of action to a senior officer, with the expectation that the senior officer will make a decision based on the courses of action presented to him after the briefing (Department of the Army 2011d). Each course of action is judged according to two sets of criteria. The first is the screening criteria, which is a set of criteria that all courses of action must meet to be considered an appropriate course of action. To be an appropriate course of action, the course of action must be feasible, acceptable, suitable, distinguishable, and complete (Department of the Army 2011d, B.15). The second set of criteria is the evaluation criteria, which consists of factors that the deciding officer and the staff will use to "measure the relative effectiveness and efficiency of one [course of action] relative to other [course of action]" (Department of the Army 2011d, B.14). Using the evaluation criteria, the senior officer will determine which course of action is the best for a given mission or task.

In light of the *ANC Campaign Plan*, senior Army Nurses were given the mission of developing adaptive junior Army Nurses. This thesis proposes one course of action, the use of the LCM-based counseling tool, in guiding the self-development of each junior Army Nurse. Grading this course of action based on evaluation criteria is beyond the scope of this thesis because no other course of action has been proposed throughout the document and, therefore, the comparison required to implement evaluation criteria is not

possible. Assessing the appropriateness of the LCM-based counseling tool using the screening criteria of the military decision-making process, however, is possible based solely on the merits of the tool itself.

To be an appropriate course of action, the LCM-based counseling tool must first be deemed feasible, meaning that it can accomplish the mission (developing adaptive junior Army Nurses) within the established time, space, and resource limitations (Department of the Army 2011d, B.15). First, can the LCM-based counseling tool accomplish the mission? Because the LCM is based on capability development, rather than competency development, using the LCM to guide junior Army Nurse development is inherently adaptive. Capable leaders, as noted in chapter 4, are those who are mature enough to adapt their use of acquired competencies according to varying conditions. The LCM provides specific objectives that represent the three levels of capability necessary in the ANC. Army Nurses who achieve these objectives are adaptive for the defined level of leadership (tactical, organizational, or strategic).

Second, can use of the LCM-based counseling tool accomplish the mission within the established time, space, and resource limitations? The LCM-based counseling tool requires very little space or other resources for its use. The greatest limitation of resources will be that of time. As noted in chapters three and four, evidence demonstrates that formal developmental counseling is seldom completed. Time is one resource that is never in abundance for Army leaders (Wong 2002) and many senior officers may believe that formal development is one area that can be placed in a lower priority than other tasks and requirements. However, considering the importance of leadership development to the ANC and the Army, time spent counseling and developing junior Army Nurses is an

investment that will pay dividends in the future. Though the LCM-based counseling tool requires a significant time investment, its use will likely result in the development of adaptive junior Army Nurses and otherwise not resource intensive. It is, therefore, a feasible course of action for the development of adaptive junior Army Nurses.

As an acceptable course of action, the advantages gained by using the LCM-based counseling tool must be balanced against the associated costs and risks (Department of the Army 2011d, B.15). The greatest cost associated with the use of the LCM-based counseling tool is the investment of time on behalf of the junior and senior Army Nurses. To adequately interact with, and guide, the junior Army Nurse, the senior officer may be required to work around the junior officer's work schedule, especially in the bedside clinical environment where junior Army Nurses work a variety of irregular shifts. Further, the junior Army Nurse may be required to attend counseling sessions outside his regular work schedule due to patient care loads. In terms of risk, one could argue that all personal interaction between junior and senior leaders carries some level of risk, be it a feeling of intimidation, discomfort, or inadequacy on the part of either officer. By using the LCM-based counseling tool, however, the Army Nurses assume a limited amount of risk because the tool provides structure to the interaction and is focused on the junior Army Nurse. Relatively speaking, the costs and risks associated with the use of the LCM-based counseling tool are minimal compared to the potential advantages gained by the development of adaptive junior Army Nurses. Based on this discussion, the LCM-based counseling tool is an acceptable course of action for the development of adaptive junior Army Nurses.

To be a suitable course of action, use of the LCM-based counseling tool must result in adaptive junior Army Nurses within the intent and planning guidance of the Chief of the ANC (Department of the Army 2011d, B.15). Because the LCM was developed as a result of the *ANC Campaign Plan*, its use in the development of adaptive junior Army Nurses is inherently in keeping with the intent and planning guidance of the Chief of the ANC. The identified end state for the *ANC Campaign Plan* identifies that Army Nurses are to be "transformed . . . into full spectrum leaders, agile and responsive to all conditions-based missions" (Army Nurse Corps 2009). Army Nurses developed in accordance with the LCM may be more capable and therefore more adaptive to the conditions in which he finds himself. Using the LCM-based counseling tool to develop adaptive junior Army Nurses, then, is a suitable course of action.

Distinguishability of a course of action is requires that the course of action differ significantly from another course of action (Department of the Army 2011d, B.15). Because no other course of action is directly offered in this thesis, and therefore no comparison can be made to the LCM-based counseling tool, the distinguishability of the tool may not be readily apparent. When one considers the LCM-based counseling tool as a part of the self-development domain of leadership development, its use is distinguishable from the other leadership development domains (institutional training and operational assignments) (Department of the Army 2007b; Department of the Army 2009a). Institutional training is, by its nature, mandatory training that enhances the officer's ability to accomplish the tasks related to his daily duties. As noted in chapter 3, institutional training is standardized across the force and takes into account very little about the personal and professional needs of the officer. Operational assignments provide

the officer some level of individualized development because his strengths and weaknesses will be identified during such assignments. In the larger Army, these assignments provide numerous opportunities for the officer to reflect on his experiences and grow. Early assignments for Army Nurses, however, are heavily focused on clinical competency development (Center for Army Leadership 2008, 2.1-2.2), which tends to overshadow the need to develop capable junior leaders. The LCM-based counseling tool is distinct in its focus on the individual officer and its focus on leadership capabilities rather than clinical competencies. The LCM-based counseling tool is distinguishable enough to be an appropriate course of action for the development of adaptive junior Army Nurses.

A complete course of action is one that accounts for the actions or responsibilities of all parties involved while also taking into account all of the aspects of mission accomplishment (Department of the Army 2011d, B.15). As a coaching and self-development tool, the LCM-based counseling tool is an ideal method of integrating all aspects of leadership development into the growth and maturation of the junior Army Nurse. Guided by the tool, the senior Army Nurse engages the junior Army Nurse about his past experiences, causing him to reflect on those experiences and grow. Additionally, the senior Army Nurse encourages the junior Army Nurse to seek professional, academic, and personal experiences that move the junior Army Nurse towards his personal and professional end states. Through a complete and fully integrated counseling process, the LCM-based counseling tool enables a guided self-development that accounts for the other two leadership development domains (institutional training and operational assignments), making it a complete course of action.

The LCM-based counseling tool is an appropriate method of developing the adaptive junior Army Nurses as called for in the *ANC Campaign Plan*. The LCM-based counseling tool serves as the key to linking the leadership development domains and enables the junior Army Nurse to reflect and grow from the experiences gained in all domains. And while the LCM-based counseling tool is an acceptable course of action, the author cannot attest to the efficacy or efficiency of the tool compared to other methods of leadership development without using some sort of evaluation criteria. To properly evaluate the LCM-based counseling tool in comparison to other leadership development courses of action, the Chief of the ANC or the Leadership Imperative Action Team must establish a set of evaluation criteria against which the courses of action can be judged.

Unexpected Findings

Within the primary research question presented in chapter 1 (how should the ANC develop adaptive junior leaders?) is an implied dissatisfaction with the methods currently employed to develop adaptive junior Army Nurses. As one reads chapter 3, he may also detect an undertone of discontent with the way leaders in the larger Army are developed today. According to the data presented in chapter 3, junior Army officers want time for deliberate, face-to-face development from their superior officers (Tan 2011). Much of the data indicated that junior leaders were dissatisfied with the current leader development system, specifically the institutional training, because the content seemed to accomplish very little in terms of leadership development (Hatfield et al. 2011). Other junior leaders were frustrated that the Army leader development system seemed to allow, or sometimes enable, the advancement of toxic leaders (Riley et al. 2011; Steele 2011). Furthermore, Army officers rated their superiors as ineffective at developing the leadership skills of

others and rated institutional training as ineffective at preparing the officers to develop their subordinates (Riley et al. 2011). Generally speaking, junior Army officers believe that Army institutional training falls short of preparing junior officers to lead at the next level and the officers' interactions with their superiors (during their operational assignments) do not provide enough quality feedback to truly develop as a leader.

In the AMEDD, there is a slight difference among junior officers. According to the Center for Army Leadership, AMEDD officers tend to rate their leadership preparation during institutional training as relevant and effective (2008). This is surprising given that less training time is spent on leadership in the AMEDD institutional training compared to the training curriculum for other Army officers (Bolton et al. 2011; Center for Army Leadership 2008). AMEDD officers also seem to be satisfied with the leadership development that occurs during their operational assignments (Center for Army Leadership 2008). Further investigation, however, does indicate that senior mission commanders (tactical, non-AMEDD commanders, generally at the rank of colonel and higher) and senior AMEDD officers tend to rate AMEDD leader capability as "slightly more negative than positive" (Center for Army Leadership 2008, ES.7), demonstrating that while the individual AMEDD officer may believe he is prepared to lead, his subordinates believe the AMEDD officer has not been developed fully in preparation for the position of leadership.

ANC-specific points of view are more congruent with the underlying tone of this thesis. Data from the Center for Army Leadership provided a lukewarm assessment of Army- and AMEDD-provided institutional training (resident and non-resident courses), rating operational assignments and interaction with their superiors much more effective at

developing leaders (2011). Army Nurses also noted that their leaders seemed unprepared to lead at the next level (Center for Army Leadership 2011). So, while the AMEDD studies seem to indicate an unexpected overall approval of AMEDD officer leadership development, ANC-specific data is consistent with the underlying tone of the primary research question in this thesis.

Recommendations

A great deal of information and data on leadership development is currently available for Army leaders to review and develop courses of action that may result in the adaptive, agile Army leader necessary for the future operating environment. In this thesis, the author gathered available data, analyzed it, and synthesized it into a new method to develop junior Army Nurses who can comfortably operate in such operating environments. The LCM-based counseling tool is a method of structuring guided self-development in the ANC and focuses the junior and senior Army Nurse on the junior officer's personal and professional objectives. By grounding the officer's development in the LCM, his development is likely to produce an adaptive Army Nurse who is prepared to lead in chaotic operating environments. Developing an Army Nurse to be an adaptive leader is not the only step in "building the bench" of the ANC (Army Nurse Corps 2009). The ANC must also invest in a system of talent management that identifies Army Nurses who have attained various capabilities, competencies, and talents. Such a system allows assignment officers to place the right Army Nurse in the right position at the right time and is likely to increase the overall assignment satisfaction for all stakeholders. Full implementation of any of these recommendations, however, requires the ANC to further test the LCM and its value in developing adaptive Army Nurses.

Emphasize Guided Self-Development

Institutional training and operational assignments in the ANC alone are not conducive to leadership development. To adequately prepare the Army Nurses officer corps for the clinical mission of the organization, much of the institutional training conducted in the ANC is focused on the officer's clinical competency. This focus is necessary given the clinical mission of the ANC but can also prevent the development of healthcare leaders who are poised to lead in chaotic environments that may arise in combat and non-combat situations. Operational assignments for Army Nurses may provide an avenue of leadership development that is varied enough to gain some level of adaptability within an operating environment. However, these experiences are relatively few in number, thus limiting the number of Army Nurses who can actually gain from such assignments. The gap-fill for any leadership development shortfalls might be the LCM-based counseling tool, which implements the self-development domain of leadership development.

To develop adaptive junior Army Nurses, the ANC needs to emphasize the use of guided self-development as a means of accommodating for the officer's circumstances, goals, preferences, challenges, and strengths. Every Army Nurse is an individual, with unique talents and characteristics, who cannot be developed in exactly the same manner as his peers. Implementing the LCM-based counseling tool as a method of guiding the junior Army Nurse's self-development grounds his development in the leadership capability needs of the Army but also provides the flexibility to structure one's development around those unique considerations. Senior Army Nurses are well situated to positively impact the development of the junior officers in their organization. To

achieve the end state of the *ANC Campaign Plan*, it is incumbent upon those senior Army Nurses to develop their junior officers in accordance with the LCM.

To begin the process of developing adaptive leaders in the ANC, the organization must formally implement the LCM-based counseling tool throughout the ANC, requiring use of the tool at every counseling session. The LCM-based counseling tool should be used in concert with the junior officer's OER support form to guide his self-development throughout his career. The LCM-based counseling tool, though apparently designed to cover only one year of time (four quarters of counseling), should be living document that is referenced and altered throughout an Army Nurse's entire career and follows him from one assignment or duty position to another. This allows subsequent leaders to understand the Army Nurse's past development recommendations and requirements, and gauge future developmental needs. At retirement, an Army Nurse with twenty years of military experience should have twenty completed LCM-based counseling tools, through which one could follow a path of capabilities development that culminates in the Army Nurse's completion of a fulfilling and adaptive career.

Command-level involvement in leadership development signals to the junior Army Nurse that the organization is investing in his personal and professional objectives. Such involvement will permeate the organizational culture at all levels (Schirmer et al. 2008) and result in a clearer understanding that leadership development is a priority for the ANC. One might argue that instituting the LCM-based counseling tool across the ANC places an additional burden on the senior Army Nurse in a time-strapped system that already requires innumerable reports and points of data for the daily patient care mission (Kirby 2011; Schirmer et al. 2008). When used correctly, the LCM-based

counseling tool will drive leadership development throughout the organization and officers (junior and senior) will begin to see results. Based on those results, Army Nurses will be willing to sacrifice their time in exchange for gaining valuable, reinforcing feedback that demonstrates the organization's commitment to the individual officer (Wardynski, Lyle, and Colarusso 2010a).

LCM-based Talent Management

Any leader development strategy must be coupled with a talent management process in order to reap the full benefits of the program. The organization must also capture information on the talents and capabilities of its personnel to make optimal use of them (Wardynski, Lyle, and Colarusso 2010a, 28-29). Currently, the ANC Branch of U.S. Army Human Resources Command is transforming the assignment process to integrate several different tools (Nagra 2011). As a part of the new process, Human Resources Command is developing a comprehensive profile of each Army Nurse's skills, knowledge, and behaviors. The profile, which will gather data from OERs submitted on each officer, will identify core behaviors and unique behaviors that each Army Nurse might possess. When standardized terminology is found in the OER, the information is indicated on the officer's profile, which is then compared to a list of capabilities and competencies for each duty position. Those officers with the highest number of capability and competency matches for a position are considered for assignment to that position (Nagra 2011).

To fully empower the individual Army Nurse, and allow him to develop in accordance with his personal and professional objectives, the talent management process should be transparent to each individual. Army Nurses need to have access to the

centralized file that identifies their progression through the LCM. This centralized file, also accessible by personnel at ANC Branch of U.S. Army Human Resources Command, allows the officer to see his progress along the LCM over time, while also providing the officer insight into what the assignments personnel understand about his progress along the LCM. An officer's interpretation of evaluations, LCM progression, or the acquisition of various skills, knowledge, and behaviors, may be different than ANC Branch at Human Resources Command. This transparent system, which aligns the capabilities and competencies between the Army Nurse and the duty assignment, would provide an objective means of placing officers into the assignments for which he is best suited. Additionally, the information provided through this transparent system provides the Army Nurse another method of receiving feedback, which can then direct the officer's self-development.

Further Study

In his manuscript as a part of the U.S. Army War College literary series, *The Letort Papers*, Dr. James Pierce, a retired Army colonel and the current director of publications at the Strategic Studies Institute, cites empirical data that demonstrates a "lack of congruence between the U.S. Army professional culture and the professional development programs" (2010, xiv). Pierce continues, noting that respondents to his study indicated their perception that the Army, at the highest levels, is characterized by a desire for stability, control through a policy-laden bureaucracy, and competitiveness. The same respondents further believed that the culture should be one of flexibility, discretion, participation, innovation, creativity, risk-taking, and a long-term commitment to professional growth. The latter, Pierce argues, is a culture that is more congruent with the

Army's (and the nation's) strategic external environment (2010). While the rest of the Army may continue to struggle with the linkage between the current operational environment and the development of adaptive leaders who tear down barriers placed in front of them, the LCM-based counseling tool, in concert with a corresponding talent management system, may link the ANC strategic environment (represented by the *ANC Campaign Plan*) and the development and growth of future ANC leaders.

To prove such a linkage, further study must be undertaken to measure the efficacy of the LCM and the LCM-based counseling tool. At its young age, the LCM has not been implemented fully throughout the ANC and its effect in developing adaptive Army Nurses cannot yet be shown. Additionally, the LCM-based counseling tool has yet to be tested in any setting and therefore its effect and utility is unknown. Further study should focus on implementing the LCM and the LCM-based counseling tools in pilot environments before the tools are implemented across the ANC. Such methodological approaches might include collecting quantitative and qualitative feedback on the capabilities, objectives, and measurable goals of the LCM, as well as the use of the LCM-based counseling tool as a framework for regular feedback. Should the LCM and the LCM-based counseling tool be correlated with a positive inflection in leadership development throughout the ANC, their universal implementation might be justified.

Summary

Leadership in today's military environment is more important than perhaps any other time in American history. General Martin E. Dempsey, the current Chairman of the Joint Chiefs of Staff, notes that the changes in United States military future, to include transitioning from a war-time military to a military of relative peace, will test military

leadership at every level. Coupled with the transition to a resource-constrained economic environment and an increasingly competitive security environment, military leaders will find themselves challenged in ways that few other generations have experienced (2012). These challenges are reflected in the leadership challenges experienced in the ANC.

Nested within the *National Security Strategy*, the *National Military Strategy*, and the *Army Posture Statement* is the *ANC Campaign Plan*, which places in high priority the development of adaptive Army Nurses who are prepared to lead no matter the chaotic conditions of the mission at hand. In this thesis, the author proposed a method for developing the adaptive junior Army Nurses integral to the success of the ANC in the future. The LCM-based counseling tool serves as a link between the *ANC Campaign Plan* (and therefore, the *National Security Strategy*) and the development of ANC leaders at the lowest levels of the organization. While the tool is untested as a method of developing adaptive junior Army Nurses, it meets the military decision-making process criteria for appropriateness as a course of action and should be considered an option to develop junior Army Nurses throughout the ANC. Further study might validate the efficacy and efficiency of the LCM-based counseling tool as well as inform future improvements and should be considered as a part of any implementation plan.

In 2009, the Chief of the ANC published the *ANC Campaign Plan* and began an effort to "create full spectrum leaders; who are creative thinkers, intrepid explorers, who can see beyond what is today to shape the future, who are adaptive to any conditions-based mission" (Army Nurse Corps 2009). This thesis is a continuation of that effort and is an effort to operationalize one portion of the plan at the lowest leadership level. In an organization such as the ANC, no other leader can have a direct impact on the leadership

development of the junior Army Nurse than his nearest supervisors. It is incumbent upon the senior Army Nurse to guide the junior officer through the three leader development domains, recognizing that he has the greatest impact on the skills, knowledge, and behaviors one might develop. Implementing and emphasizing the use of guided self-development throughout the ANC empowers leaders at the lowest level and will have the greatest impact on the development of adaptive junior Army Nurses for the future of the United States Army.

GLOSSARY

360-degree Multi-Source Assessment and Feedback. An online program established by the Department of the Army to assess officers and non-commissioned officers throughout the Army. Leaders perform a self-assessment and then request comparable feedback from those who surround them (subordinates, peers, and superiors). For the individual, the program increases "self-awareness through feedback from multiple sources across multiple levels providing leaders with a holistic means to compare their perception of their leadership competence and behaviors to that of others" (Department of the Army 2011b)

Acceptable. The course of action "must balance cost and risk with the advantage gained" (Department of the Army 2011d, B-14).

ANC leader. For the purposes of this document, the ANC leader is an Army Nurse in the rank of colonel, or higher. These officers are assigned to various positions throughout the Army Medical Department and directly impact the policies and procedures that impact all Army Nurses on a daily basis.

Area of concentration. This refers to the specialization codes assigned to Army officers based on their operational specialization. This may also be referred to as an officer's specialization. Most Army Nurses begin their career with the area of concentration designator, 66H or medical-surgical nurse. After completing specific training requirements, the Army Nurse may be granted a different area of concentration within the Army Nurse Corps (Department of the Army 2007a, 8).

Army Competitive Category officers. Army officers who are not special branch officers fall into the Army competitive category. These officers compete against each other for promotion and other competitive selection boards.

Balanced scorecard. A strategic planning and management system used to align business activities to the vision and strategy of the organization, improve internal and external communications, and monitor organization performance against strategic goals (Kaplan and Norton 1996).

Capability. "The ability of an individual or organization to extend or reconfigure competencies, or acquire new competencies, so as to deliver continued high performance in the face of rapid environmental change" (Kochikar and Ravindra 2007). Capabilities tend to reflect the broader attributes of maturity, agility, and adaptability (Stalk, Evans, and Shulman 1992; Marino 1996; Davis and Hase 1999; Conger and Ready 2004; Smallwood and Panowyk 2005; Garder et al. 2008; Smith 2008).

Center of gravity. "A source of power that provides moral or physical strength, freedom of action, or will to act. It is what Clausewitz called 'the hub of all power and

movement, on which everything depends . . . the point at which all our energies should be directed'" (Department of Defense 2011b, III-22).

Coaching. "In the military, coaching occurs when a leader guides another persons development in new or existing skills during the practice of those skills . . . coaching relies primarily on teaching and guiding to help bring out and enhance current capabilities. A coach helps those being coached to understand and appreciate their current level of performance and their potential, and instructs them on how to reach the next level of knowledge and skill" (Department of the Army 2007c, 5-6).

Complete. The course of action accomplishes the mission, includes shaping operations and decisive operations, details how the operation will be sustained, and identifies roles, responsibilities, and tasks to be completed as a part of the course of action (Department of the Army 2011d, B.15).

Core leader competency. "[R]elated behaviors that lead to successful performance, are common throughout the organization, and are consistent with the organizational mission and values . . . support the Executive core competencies (ECQs) that civilian leaders are expected to master as they advance in their careers" (Department of the Army 2007c, 3). These competencies include: leads others, extends influence beyond the chain of command, leads by example, communicate, creates a positive organizational climate, prepares self, develops others, and gets results (Department of the Army 2006, A.1-A.11; Department of the Army 2007c, 3).

Counseling. "Counseling is a standardized tool used to provide feedback to a subordinate. Counseling focuses on the subordinate by producing a plan outlining actions the subordinate can take to achieve individual and organizational goals. It is central to leader development and should be part of a comprehensive program for developing subordinates. A consistent counseling program includes all subordinates, regardless of the level of each ones potential" (Department of the Army 2007c, 5).

Distinguishable. Each course of action "must differ significantly from the others" (Department of the Army 2011d, B.15).

Ends, ways, and means. This phrase refers to the connection between an organization's objectives and end state (ends), the sequence of actions most likely used to achieve those objectives and end state (ways), and the resources required to accomplish that sequence of actions (means) (Department of Defense 2011b, II-4).

Evaluation criteria. A part of course of action development in the military decision-making process, these are "factors the commander and staff will later use to measure the relative effectiveness and efficiency of one [course of action] relative

to other [courses of action] . . . and must be clearly defined and understood by all staff members before starting . . . to test the proposed [courses of action]" (Department of the Army 2011d, B.13).

Feasible. A course of action "can accomplish the mission within the established time, space, and resource limitations" (Department of the Army 2011d, B.15).

Full spectrum operations. Formerly, "the Army's operational concept: Army forces combine offensive, defensive, and stability or civil support operations simultaneously as a part of an interdependent joint force to seize, retain, and exploit the initiative, accepting prudent risk to create opportunities to achieve decisive results" (Department of the Army 2008, Glossary-7). This term has since been replaced by the term "unified land operations" (Department of the Army 2011a).

Mentoring. Mentoring is "the voluntary developmental relationship that exists between a person of greater experience and a person of lesser experience that is characterized by mutual trust and respect. The focus of [mentoring] is voluntary mentoring that extends beyond the scope of chain of command relationships and occurs when a mentor provides the mentee advise and counsel over a period of time. Effective [mentoring] will positively impact personal and professional development" (Department of the Army 2007c, 6).

Operational assignment. An operational assignment is any military assignment in which the officer is not in an academic learning environment and exercises his authority or responsibility in accordance with his duty assignment. These assignments "translate theory into practice by placing leaders in positions to apply the knowledge and skills they acquired during institutional training and education" (Department of the Army 2007c, 5).

Range of military operations. This term refers to the use of military assets to achieve a strategic or operational end state across a spectrum of conflict that ranges from peace to war. The range of military operations encompasses the use of joint military capabilities in military engagement, security cooperation, and deterrence activities, crisis response and limited contingency operations, and major operations and campaigns (Department of Defense 2011a, V-1).

Screening criteria. As a part of the course of action development in the military decision-making process, this term refers to a set of criteria against which each course of action is measured prior to consideration for evaluation. The course(s) of action that do not meet these basic criteria will not be considered in the decision-making process (Department of the Army 2011d, B.15).

Special branch officers. Officers who are not members of the Army competitive category are special branch officers. These officers compete only against officers in their branch for promotion and other central selection boards. Officers of the Judge

Advocate General Corps, the Army Chaplaincy, and the Army Medical Department are special branch officers.

Strategy map. A graphic representation of an organization's balanced scorecard, that showes the relationships between strategic objectives. (Kaplan and Norton 2001, 65-160).

Suitable. The course of action "can accomplish the mission within the commander's intent and planning guidance" (Department of the Army 2011d, B.15).

APPENDIX A

ARMY NURSE CORPS CAMPAIGN PLAN

The following comes from the Army Nurse Corps website (Army Nurse Corps 2009) and was current as of the date of the publication of this manuscript. The emphases throughout the document are original to the plan.

> **1. SITUATION.** The nation's nursing shortage continues to have the potential to negatively impact the quality and safety of patient care both in civilian and military medical treatment facilities (MTF). Insufficient Army nursing capacity and in some cases low density specialties can threaten the viability of current and future AMEDD missions. The use of different nursing care delivery models in MTFs increases practice variance, limits the capability to codify evidence-based nursing practice and causes imbalanced nursing workload to workforce ratios across the AMEDD. An inability to offer innovative, flexible career programs that promote nursing retention further decrements the steady-state workforce that is needed for workforce optimization. An irrelevant long-range leader succession plan and appropriate force structure precludes optimization of key leader knowledge and skills required for organizational traction and momentum. No corporate, cohesive nurse training blueprint exists that leverages human capital asymmetric advantages such as junior nurses' capabilities to innovate in complex, uncertain environments that can mitigate gaps in technology and nursing capacity. The sustained increased demand for Army nurses is beginning to exceed the sustainable supply. As a result, Army nursing's ability to respond proactively to new and different contingencies is decreasing. Twenty-first century persistent conflicts demand full-spectrum Army nurses who are versatile in their ability to accomplish a broad range of tasks and agile thinkers who can exploit opportunities in complex environments. Hospital-based Army Nurse Corps' medical occupational specialities and additional skill identifiers were developed for a hospital-based environment in an era where the Army was downsizing. New MOS/ASI's are required to provide the right expeditionary and interoperable capability in support of the strength of our Nation: America's Army. Emerging global trends impacting the Army demand an analysis and optimization of the Army Nurse Corps force horizon.
>
> **2. Key Assumptions.**
>
> The nursing shortage is a looming public health crisis that has the potential to erode access to and quality of health care.
>
> Nurses are critical to meeting the increasing healthcare needs of vulnerable populations.

Competitive-edge strategies will attract and retain qualified nurses and nurse candidates from an increasingly diverse population.

Nurses have a responsibility to impact needed changes in healthcare delivery systems and models of care.

Nurses function as partners in an interdisciplinary healthcare delivery system.

Current and future military healthcare delivery systems demand predictive models that delineate required nursing capacities and capabilities.

Current and future changes in nursing workload texture demand measurement systems that capture workload quality and quantity; promote nurse staffing models and improve nursing care performance improvement.

3. Purpose. This Army Nurse Corps Campaign Plan establishes priorities for the Corps and codifies campaign planning as the systematic process for blueprinting the future. Major improvements in agility often require new work systems, simplification of work processes, or an ability to rapidly change direction towards improvement. Subsequently, a major long-term investment associated with nursing care excellence is the investment in creating and sustaining an assessment system focused on outcomes.

The priorities drive strategic planning and are conducted to nest with the AMEDD's and Army's mission and vision. These priorities include measures of effectiveness ("are we doing the right things") and measures of performance ("are we doing things right") that indicate when the priority has been accomplished and becomes sustainable. On receipt of this Plan, all Action Officers will form a process action team to develop their strategy and way ahead. The strategy must include resources required, designate benchmarks (date or condition), priority or enabling tasks identified, and a timeline for execution. The plan is evaluated yearly by the ANC Executive Board and approved by the Chief, AN. The Deputy Chief, AN evaluates progress on the plan monthly and reports accordingly to the Chief, AN. Transparency is optimum and the Chief AN will provide updates to DSG, TSG and Congress as often as requested.

An effective Army Nurse Corps depends on the continuous measurement and analysis of performance. Subsequently, campaign planning occurs yearly to evaluate performance, codify and internalize best practices and transform key work processes and systems to achieve performance excellence.

4. Army Nurse Corps Campaign Plan Mission and End State

A. Mission

Task: Re-posture the Army Nurse Corps to deliver *patient driven, family-centric evidence-based nursing care,* provide *full-spectrum leadership* for professional nursing and in support of the Army Medical Department.

Purpose: Optimize Army Nursing as a *key enabler for the Military Health System.*

Corps Chief Intent:

I intend to provide *continuous, responsive and essential nurse advocacy for the AMEDD's strategic imperatives*. All actions and tasks must lead and work toward promoting the wellness of Warriors, their families, and all entrusted to our care; supporting the delivery of patient and family healthcare and ultimately, positioning the Army Nurse Corps as a key enabler for the future of military medicine.

B. End State.

In the *near term,* the Army Nurse Corps executed effective strategies that provided evidence-based nursing care and developed full spectrum leaders; *optimized* their footprint through aggressive *validation* of priorities; *re-postured* the force structure to create current and future *capacity and capability* and maximized *performance excellence. Leveraged Strategic Communication* that *engaged* key audiences and created, strengthened and preserved conditions favorable for the advancement of Army Nurse Corps' interests and objectives. Codified a *robust* clinical delivery system *nested* with competencies, capabilities, and evidence-based ideology. *Transformed* Army Nurses into *Full Spectrum Leaders, agile* and *responsive* to all conditions-based missions.

In the *far term,* the Army Nurse Corps *codified and internalized* best organizational strategies that provided a relentless focus on organizational improvement, agility and responsiveness.

In the *long term,* the Army Nurse Corps consistently achieved performance excellence, fostered innovation, built knowledge and capabilities, and insured organizational creditability and sustainability.

5. Campaign Plan Objectives.

Leader Development *"Build our bench"*: a persistent, sustainable nurse leader succession plan created full-spectrum leaders who were adaptive to any conditions-based mission; provided a persuasive voice at key echelons of

influence in the AMEDD, and innovated doctrine to blueprint the future of the Army Nurse Corps.

Warrior Care *"Back to basics"*: optimized nursing care delivery systems that wrapped nursing capability around AMEDD strategic goals and mission; Warrior/patient driven/family-centric care models embraced evidence-based practice to achieve best patient outcomes.

Evidence-based Management *"Optimize performance"*: evidence-based methodology optimized business practices and cost-capabilities by blending analysis, measuring, and re-designing into daily performance.

Human Capital *"Portfolio of Expertise"*: the Army Nurse Corps footprint is optimized through validation of priorities and the force structure is re-postured for conditions-based capability and capacity.

Chief, Army Nurse Corps Top 10 Priorities

"All actions and tasks must lead and work toward promoting the wellness of Warriors and their families, supporting the delivery of Warrior and family healthcare and ultimately, positioning the Army Nurse Corp as a force multiplier for the future of military medicine . . . An organization that consistently achieved performance excellence, fostered innovation, built knowledge and capabilities, and insured organizational credibility and sustainability" MG Horoho

Create full-spectrum leaders; who are creative thinkers, intrepid explorers, who can see beyond what is today to shape the future, who are adaptive to any conditions-based mission, provide a persuasive voice at key echelons of influence in the AMEDD, and innovate doctrine to blueprint the future of the ANC

Validate and re-posture ANC footprint to meet future conditions-based capability and capacity

Optimize nursing care delivery "excellent" systems that are linked with competencies and capabilities, and nested with AMEDD strategic goals and missions

Embrace the Warrior Family Care Model; patients and their families can effectively master their health with the support and coaching of user friendly, responsive health systems that achieve the best patient outcomes

Foster human capital synergy which allows for optimal level of innovation, productivity and healthcare effectiveness and efficiencies

Recruit and retain highly qualified, skilled and diverse Army Nurses; improve the image of Army Nursing and promote nursing as a career choice through increased collaboration with external partners

Employ evidence-based methodology founded on the collection, interpretation, and integration of valid, important, and applicable patient-reported, nurse-observed, and research-derived evidence

Create and distribute “Public Diplomacy”; getting the right message, through the right media, to the right audience at the right time and with the right effect

Increase the practice of nurse researchers; priorities include developing and increasing evidence-based leadership capacity; education focusing on the design, implementation and evaluation of future patient care delivery models; and education and research initiatives concerning positive work environments

Position the Army Nurse Corp as a force multiplier for the future of military medicine through doctrinal change, technology, and operational art

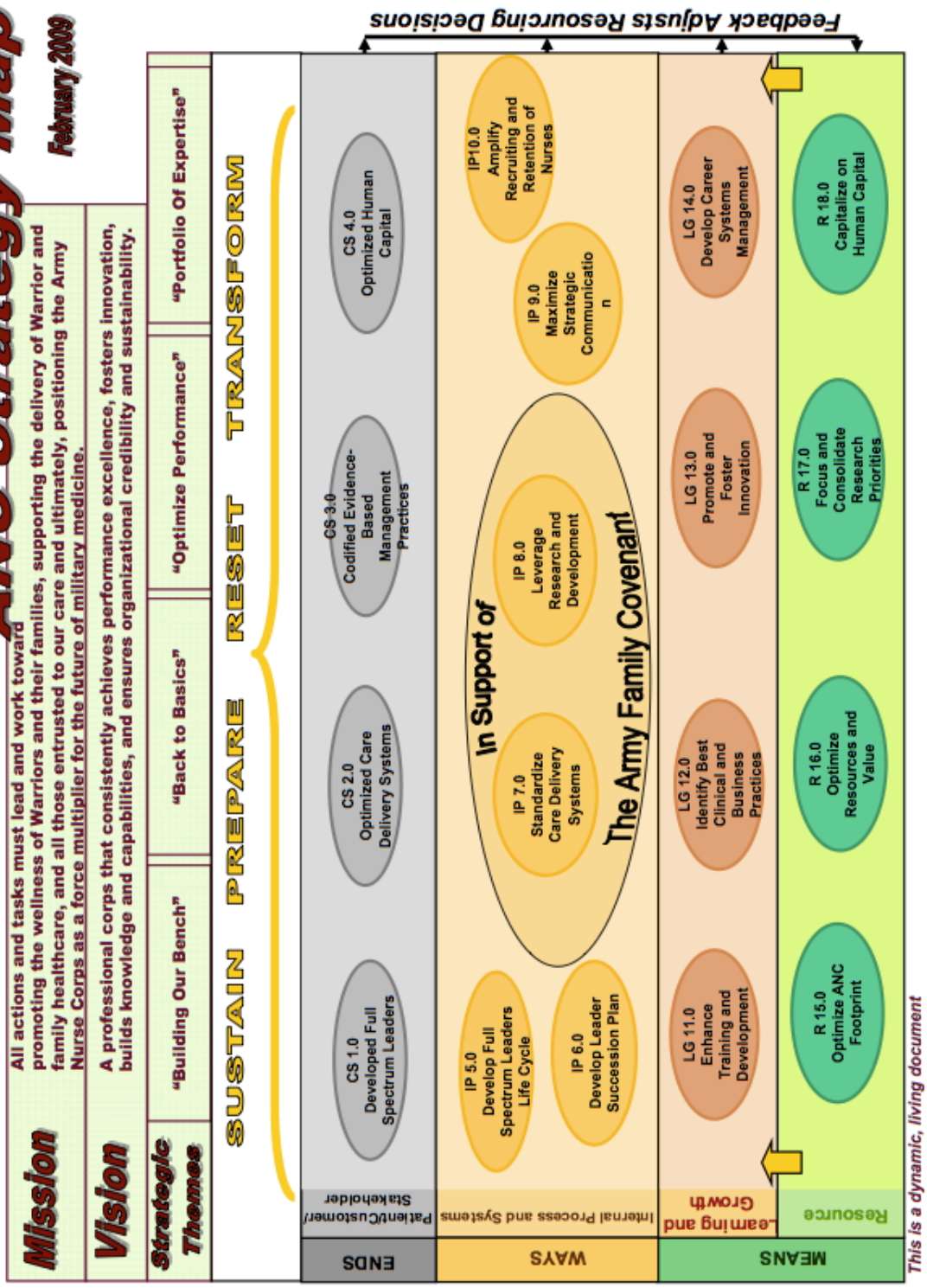
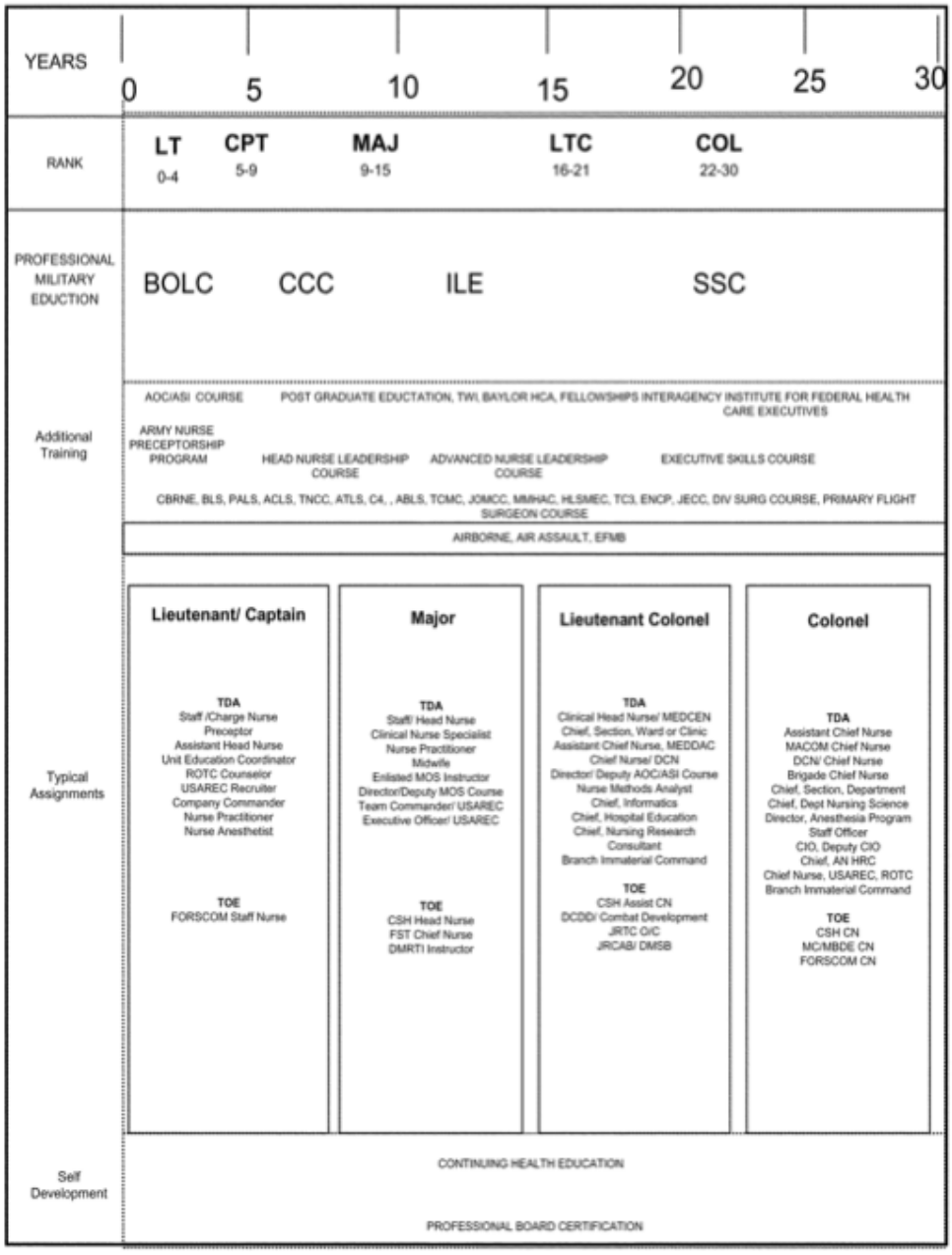


Figure A-1: Army Nurse Corps Strategic Map

Source: Army Nurse Corps, *Army Nurse Corps Campaign Plan*, 2009, http://armynursecorps.amedd.army.mil/campaign/campaignplanonwebpagemarch09.pdf (accessed 24 August 2011).

APPENDIX B

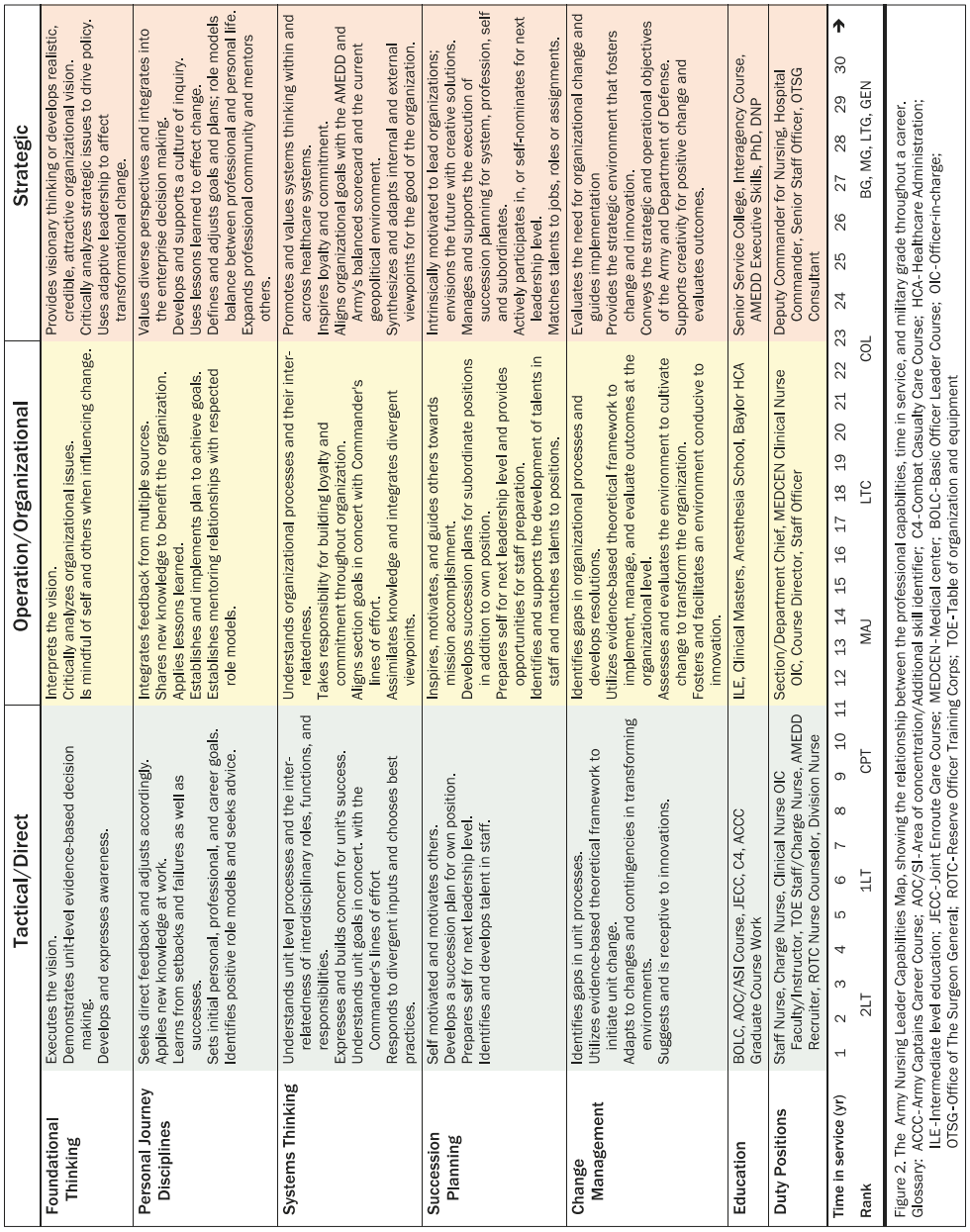
ARMY NURSE CORPS ACTIVE ARMY LIFECYCLE MODEL



Source: Department of the Army, Department of the Army Pamphlet 600-4, *Army Medical Department Officer Development and Career Management* (Washington, DC: Government Printing Office, 2007), https://www.apd.army.mil/ (accessed 1 December 2011).

APPENDIX C

ARMY NURSE CORPS LEADERSHIP CAPABILITIES MAP



	Tactical/Direct	Operation/Organizational	Strategic
Foundational Thinking	Executes the vision. Demonstrates unit-level evidence-based decision making. Develops and expresses awareness.	Interprets the vision. Critically analyzes organizational issues. Is mindful of self and others when influencing change.	Provides visionary thinking or develops realistic, credible, attractive organizational vision. Critically analyzes strategic issues to drive policy. Uses adaptive leadership to affect transformational change.
Personal Journey Disciplines	Seeks direct feedback and adjusts accordingly. Applies new knowledge at work. Learns from setbacks and failures as well as successes. Sets initial personal, professional, and career goals. Identifies positive role models and seeks advice.	Integrates feedback from multiple sources. Shares new knowledge to benefit the organization. Applies lessons learned. Establishes and implements plan to achieve goals. Establishes mentoring relationships with respected role models.	Values diverse perspectives and integrates into the enterprise decision making. Develops and supports a culture of inquiry. Uses lessons learned to effect change. Defines and adjusts goals and plans; role models balance between professional and personal life. Expands professional community and mentors others.
Systems Thinking	Understands unit level processes and the inter-relatedness of interdisciplinary roles, functions, and responsibilities. Expresses and builds concern for unit's success. Understands unit goals in concert. with the Commander's lines of effort Responds to divergent inputs and chooses best practices.	Understands organizational processes and their inter-relatedness. Takes responsibility for building loyalty and commitment throughout organization. Aligns section goals in concert with Commander's lines of effort. Assimilates knowledge and integrates divergent viewpoints.	Promotes and values systems thinking within and across healthcare systems. Inspires loyalty and commitment. Aligns organizational goals with the AMEDD and Army's balanced scorecard and the current geopolitical environment. Synthesizes and adapts internal and external viewpoints for the good of the organization.
Succession Planning	Self motivated and motivates others. Develops a succession plan for own position. Prepares self for next leadership level. Identifies and develops talent in staff.	Inspires, motivates, and guides others towards mission accomplishment. Develops succession plans for subordinate positions in addition to own position. Prepares self for next leadership level and provides opportunities for staff preparation. Identifies and supports the development of talents in staff and matches talents to positions.	Intrinsically motivated to lead organizations; envisions the future with creative solutions. Manages and supports the execution of succession planning for system, profession, self and subordinates. Actively participates in, or self-nominates for next leadership level. Matches talents to jobs, roles or assignments.
Change Management	Identifies gaps in unit processes. Utilizes evidence-based theoretical framework to initiate unit change. Adapts to changes and contingencies in transforming environments. Suggests and is receptive to innovations.	Identifies gaps in organizational processes and develops resolutions. Utilizes evidence-based theoretical framework to implement, manage, and evaluate outcomes at the organizational level. Assesses and evaluates the environment to cultivate change to transform the organization. Fosters and facilitates an environment conducive to innovation.	Evaluates the need for organizational change and guides implementation Provides the strategic environment that fosters change and innovation. Conveys the strategic and operational objectives of the Army and Department of Defense. Supports creativity for positive change and evaluates outcomes.
Education	BOLC, AOC/ASI Course, JECC, C4, ACCC Graduate Course Work	ILE, Clinical Masters, Anesthesia School, Baylor HCA	Senior Service College, Interagency Course, AMEDD Executive Skills, PhD, DNP
Duty Positions	Staff Nurse, Charge Nurse, Clinical Nurse OIC Faculty/Instructor, TOE Staff/Charge Nurse, AMEDD Recruiter, ROTC Nurse Counselor, Division Nurse	Section/Department Chief, MEDCEN Clinical Nurse OIC, Course Director, Staff Officer	Deputy Commander for Nursing, Hospital Commander, Senior Staff Officer, OTSG Consultant

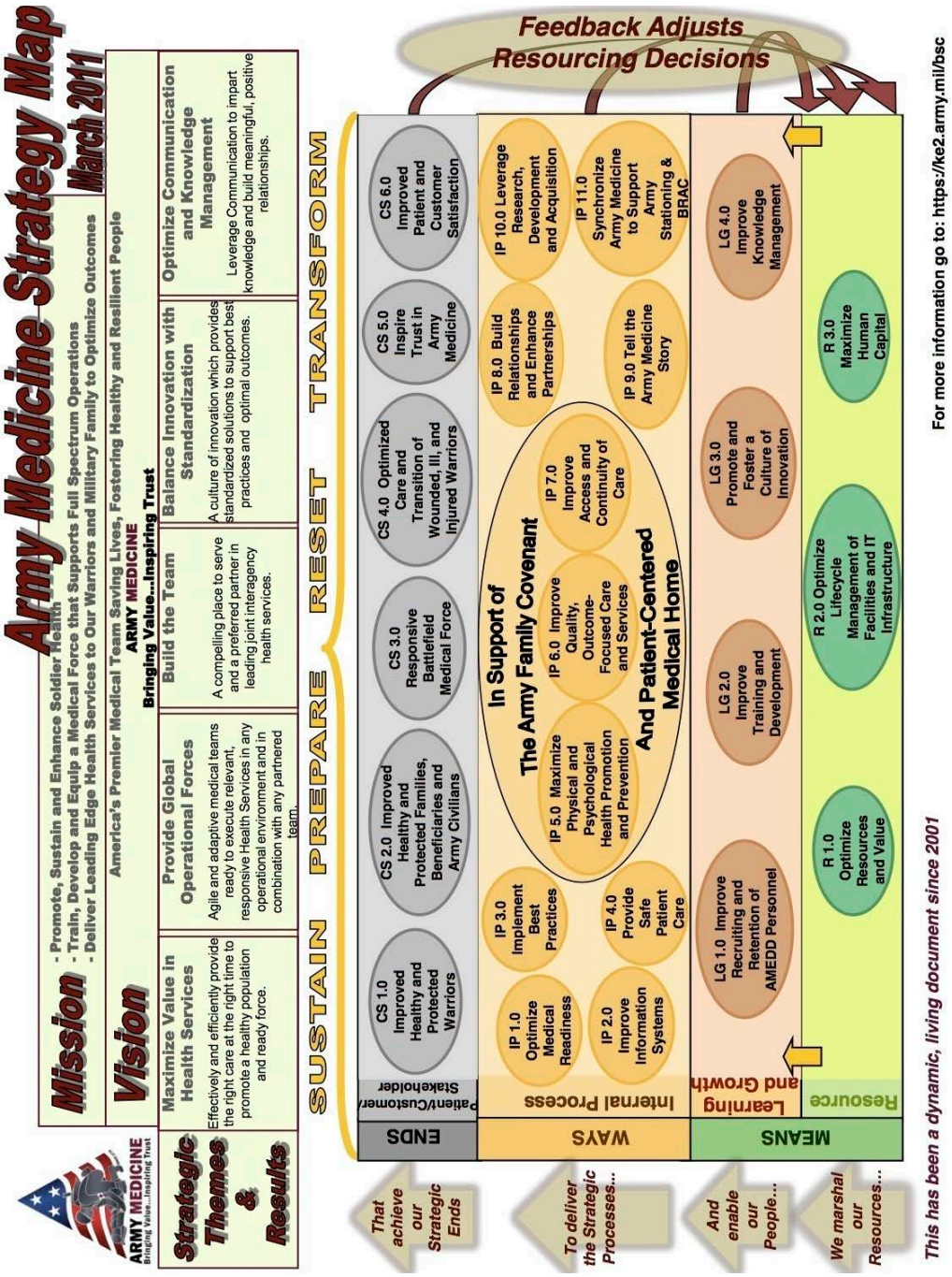
Time in service (yr)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	→
Rank	2LT					1LT				CPT				MAJ				LTC					COL				BG, MG, LTG, GEN				

Figure 2. The Army Nursing Leader Capabilities Map, showing the relationship between the professional capabilities, time in service, and military grade throughout a career.
Glossary: ACCC-Army Captains Career Course; AOC/SI-Area of concentration/Additional skill identifier; C4-Combat Casualty Care Course; HCA-Healthcare Administration; ILE-Intermediate level education; JECC-Joint Enroute Care Course; MEDCEN-Medical center; BOLC-Basic Officer Leader Course; OIC-Officer-in-charge; OTSG-Office of The Surgeon General; ROTC-Reserve Officer Training Corps; TOE-Table of organization and equipment

Source: Kathleen Dunemn, Denise L. Hopkins-Chadwick, Tina Connally, and Kelly Bramley, "Designing and implementing the Army Nursing Leader Academy," *The United States Army Medical Department Journal* (October-December 2011): 18-23, http://www.cs.amedd.army.mil/AMEDDJournal/OctDec2011.pdf (accessed 31 December 2011).

APPENDIX D

ARMY MEDICAL DEPARTMENT STRATEGY MAP



Source : Army Medical Department, *Army Medical Department Strategy Map*, March 2011, http://www.amedd.army.mil/about/BalancedScorecard.pdf (accessed 1 November 2011).

APPENDIX E

LCM TO 360-MSAF CAPABILITY/COMPETENCY CROSSWALK

The following tables were developed by the author to link the data derived from the 360-MSAF to the capability objectives of the LCM. Through this linkage, the senior Army Nurse can guide the junior officer through self-development based on feedback he receives via the 360-MSAF. The author annotated the linkages between the two tools based on the definitions or descriptions available for each item. First, using the interactive LCM (Army Nurse Corps 2011), the author drilled down to the measurable goals for each capability objective at the tactical level. The measurable goals were then compared to the specific competency actions described in Army Field Manual 6-22 (Department of the Army 2006, A.1-A.11) and the 360-MSAF (Department of the Army 2011c). If the measurable goal of the LCM and the competency action were approximately equal, the author annotated the connection.

Table E-1. LCM to 360-MSAF Capability/Competency Crosswalk

Army Nurse Corps Leadership Capabilities (as listed on the Leadership Capabilities Map)

		Leadership Competencies and Behaviors (as listed in FM 6-22 and the 360-MSAF)																																		
Leader Capabilty	**Leader Capability Objectives**	***Prepare Self to Lead***	Maintains own physical health	Keeps current with world affairs and geo-political situations	Improves ability in interpersonal interaction	Recognizes how own actions impact others	Considers and uses personal feedback received from others	Maintains relevant cultural understanding	Improves own capability for complex thought	Increases knowledge applicable to own current position	Develops knowledge applicable to future positions	Monitors and reduces stress to maintain mental well-being	Is self-aware	***Overall Leadership***	Leads others successfully when there is direct threat to physical well-being or survival	Inspires individuals and organizations to do their best	Makes tough, sound decisions on time	Balances near-term mission success with sustained improvement in the organization	Does what it takes to be a highly proficient leader	Ensures personnel and organizations accomplish their mission	Clearly explains missions, standards, and priorities	Remains calm under pressure	Sees the big picture	Adapts quickly to new situations and requirements	***Lead Others***	Creates and shares a vision of the future	Uses appropriate influence techniques to energize others	Conveys the significance of the work	Maintains and enforces high professional standards	Establishes clear intent and purpose	Balances requirements of mission with welfare of followers
Foundational Thinking																																				
	Executes the Vision															X		X		X	X	X		X		X		X	X	X						
	Demonstrates unit level evidence-based decision making								X	X							X				X															
	Develops and expresses self-awareness				X	X	X		X	X	X		X							X						X									X
Personal Journey Disciplines																																				
	Seeks direct feedback and adjusts accordingly				X	X	X	X					X							X															
	Applies new knowledge at work								X	X	X		X		X		X			X															
	Learns from setback and failures as well as successes				X	X	X	X					X				X			X															
	Sets initial personal, professional, and career goals								X	X	X					X				X															
	Identifies positive role models and seeks advice							X		X	X					X				X															
Systems Thinking																																				
	Understands unit level processes and the inter-relatedness of inter-disciplinary roles, functions, and responsibilities								X	X	X										X	X		X						X					X
	Expresses and builds concerns for unit's success															X	X		X	X	X	X				X	X	X	X			X			X
	Understands unit goals in concert with the Commander's lines of effort															X	X		X	X	X	X		X		X			X	X	X				
	Responds to divergent inputs and chooses best practices								X	X	X							X			X									X					
Succession Planning																																				
	Self motivated and motivates others						X			X	X						X			X	X					X	X			X					X
	Develops a succession plan for own position						X												X	X		X		X											
	Prepares self for next leadership level										X								X	X				X											
	Identifies and develops talent in staff						X										X		X		X			X						X					X
Change Management																																				
	Identifies gaps in unit processes								X										X		X			X	X		X			X					
	Utilize evidence based theoretical framework to initiate unit change									X								X							X					X					
	Adapts to changes and contingencies in transforming environments																	X	X	X	X	X			X										
	Suggests and is receptive to innovations									X									X	X	X	X			X		X								

Table E-1 (continued).

Leadership Competencies and Behaviors (as listed in FM 6-22 and the 360-MSAF)

Army Nurse Corps Leadership Capabilities (as listed on the Leadership Capabilities Map)

Leader Capabilty	Leader Capability Objectives	***Lead by Example***	Own actions are consistent with guidance given to others	Leads with confidence in adverse situations	Models Army values consistently through actions, attitudes, and communications	Displays the knowledge and skills required by position	Is open to diverse ideas and points of view	Uses critical thinking and encourages others to do the same	Demonstrates commitment to the Nation, U.S. Army, one's unit, and Soldiers	Exemplifies warrior ethos	***Get Results***	Seeks, recognizes, and takes advantage of opportunities to improve organizational performance	Prioritizes tasks for teams or groups	De-conflicts roles among individuals or teams	Makes appropriate assignments or role delegation to subordinates or teams	Accomplishes the mission	Recognizes and rewards good performance	Adjusts to external influences on the mission and organization	Removes work barriers or insulates subordinates from them	Accounts for differences in individual's commitment to tasks or missions when managing work	Incorporates feedback as a routine part of work	Accounts for differences in individual and group capabilities when assigning tasks or missions	Contends for and provides resources to help subordinates perform their duties	***Extend influence beyond chain of command***	Negotiates with others to reach mutual understanding and to resolve conflict	Uses diplomacy appropriately	Understands the extent of influence outside the chain of command	Builds and maintains alliances	Sets the proper tone for dealing with others beyond the chain of command	Proactive in extending influence beyond the chain of command	Adjusts influence techniques to the situation and parties involved	Builds trust with those outside lines of authority
Foundational Thinking																																
	Executes the Vision		X	X	X	X			X	X			X		X	X							X		X							
	Demonstrates unit level evidence-based decision making					X		X				X		X						X	X	X										
	Develops and expresses self-awareness				X	X																				X	X	X	X	X	X	X
Personal Journey Disciplines																																
	Seeks direct feedback and adjusts accordingly		X			X															X						X	X	X			
	Applies new knowledge at work					X		X																								
	Learns from setback and failures as well as successes					X		X													X						X	X	X			
	Sets initial personal, professional, and career goals					X																										
	Identifies positive role models and seeks advice		X		X	X	X														X											
Systems Thinking																																
	Understands unit level processes and the inter-relatedness of inter-disciplinary roles, functions, and responsibilities					X		X				X	X	X				X								X	X	X	X	X	X	X
	Expresses and builds concerns for unit's success				X							X					X			X		X	X		X	X						X
	Understands unit goals in concert with the Commander's lines of effort		X	X	X	X			X	X			X			X							X		X	X	X	X	X	X	X	X
	Responds to divergent inputs and chooses best practices					X	X											X					X									
Succession Planning																																
	Self motivated and motivates others				X	X		X				X			X		X			X		X			X	X		X		X	X	X
	Develops a succession plan for own position					X			X	X		X			X					X												
	Prepares self for next leadership level				X	X																								X	X	X
	Identifies and develops talent in staff							X	X	X		X			X		X			X		X										
Change Management																																
	Identifies gaps in unit processes					X						X						X					X									
	Utilize evidence based theoretical framework to initiate unit change					X		X				X						X			X		X		X							
	Adapts to changes and contingencies in transforming environments			X		X						X						X					X		X							
	Suggests and is receptive to innovations			X		X	X	X				X						X					X		X							

Table E-1 (continued).

Army Nurse Corps Leadership Capabilities (as listed on the Leadership Capabilities Map)

		Leadership Competencies and Behaviors (as listed in FM 6-22 and the 360-MSAF)																												
Leader Capabilty	**Leader Capability Objectives**	***Develops leaders***	Actively encourages the development of others	Coaches others in the development or improvement of skills	Fosters leader development by structuring jobs that challenge subordinates	Encourages development of team skills	Fosters growth in others	Fosters subordinate leader development through job assignment	Serves as a mentor over an extended period of time	Provides appropriate feedback to subordinates	***Creates a positive environment***	Creates a learning environment	Has high performance expectations for individuals and teams	Anticipates people's on-the-job needs	Encourages subordinates to accept responsibility	Encourages fairness	Fosters teamwork and cooperation	Handles reasonable setbacks as an expected part of operations	Demonstrates care for people and their well-being	Encourages open and candid communications	***Communicate***	Keeps others informed	Presents recommendations with clarity	Expresses ideas so they can be understood by the audience	Engages others with appropriate communication techniques	Listens actively	Achieves shared understanding	Demonstrates sensitivity to cultural factors in communication
Foundational Thinking																														
	Executes the Vision					X		X		X							X													
	Demonstrates unit level evidence-based decision making											X											X	X						
	Develops and expresses self-awareness																	X	X	X			X		X	X		X		
Personal Journey Disciplines																														
	Seeks direct feedback and adjusts accordingly																			X										
	Applies new knowledge at work																						X							
	Learns from setback and failures as well as successes																	X												
	Sets initial personal, professional, and career goals																													
	Identifies positive role models and seeks advice																			X										
Systems Thinking																														
	Understands unit level processes and the inter-relatedness of inter-disciplinary roles, functions, and responsibilities				X									X		X		X												
	Expresses and builds concerns for unit's success		X	X	X	X	X	X				X	X	X	X	X	X	X	X	X		X			X	X	X	X		
	Understands unit goals in concert with the Commander's lines of effort																	X				X			X	X	X	X		
	Responds to divergent inputs and chooses best practices												X	X				X		X										
Succession Planning																														
	Self motivated and motivates others		X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X		X			X	X	X	X		
	Develops a succession plan for own position		X	X	X	X	X	X				X	X		X		X													
	Prepares self for next leadership level																													
	Identifies and develops talent in staff		X	X	X	X	X	X	X	X		X	X		X		X													
Change Management																														
	Identifies gaps in unit processes				X		X	X				X	X	X		X														
	Utilize evidence based theoretical framework to initiate unit change				X		X	X				X	X			X							X	X						
	Adapts to changes and contingencies in transforming environments				X		X	X				X	X																	
	Suggests and is receptive to innovations				X		X	X				X	X							X			X							

Sources: Created by author. Adapted from Army Nurse Corps, *Army Nurse Corps Campaign Plan*, http://armynursecorps.amedd.army.mil/campaign/campaignplan onwebpagemarch09.pdf (accessed 24 August 2011); Department of the Army, Field Manual 6-22, *Army Leadership (competent, confindent, and agile)* (Washington, DC: Government Printing Office, October 2006), A.1-A.11; Department of the Army, *Army 360 Multi-Source Assessment and Feedback (MSAF), Frequently Asked Questions*, http://msaf.army.mil/Help/FAQ.aspx (accessed 25 September 2011).

APPENDIX F

LCM TO PES-NWI CROSSWALK

The author developed the following table to demonstrate the linkages between the LCM and the PES-NWI. While not competency-based, the feedback received from the PES-NWI provides senior Army Nurses an additional perspective when assessing the developmental needs of his subordinate Army Nurses.

Table F-1. LCM to PES-NWI Crosswalk

Subscales of the Practice Environment Scale of the Nursing Work Index (PES-NWI)

Army Nurse Corps Leadership Capabilities (as listed on the Leadership Capabilities Map)

Leader Capabilty	Leader Capability Objectives	***Nurse Participation in Hospital Affairs***	Career development/clinical ladder opportunity	Opportunity for staff nurses to participate in policy decisions	A chief nurse who is highly visible and accessible to staff	A chief nurse equal in power and authority to other top-level hospital executives	Opportunities for advancement	Administration that listens and responds to employee concerns	Staff nurses are involved in the internal governance of the hospital	Staff nurses have the opportunity to serve on hospital and nursing committees	Head nurses consult with staff on daily problems and procedures	***Nursing Foundations for Quality Care***	Active staff development or continuing education programs for nurses	High standards of nursing care are expected by the administration	A clear philosophy of nursing that pervades the patient care environment	Working with nurses who are clinically competent	An active performance improvement program	A preceptor program for newly hired RNs	Nursing care is based on a nursing rather than a medical model	Written, up to date nursing care plans for all patients	Use of nursing diagnoses	Patient care assignments that foster continuity of care	***Nurse Manager Ability, Leadership, and Support***	A supervisory staff that is supportive of nurses	A head nurse who is a good manager and leader	Praise and recognition of a job well done	Supervisors use mistakes as learning opportunities, not criticism	A head nurse who backs up the nursing staff in decision making, even if the conflict is with a physician	***Staffing and Resource Adequacy***	Adequate support services allow me to spend time on my patients	Enough time and opportunity to discuss patient care problems with other nurses	Enough registered nurses on staff to provide quality patient care	Enough staff to get the work done	***Collegial Nurse-Patient Relationships***	Physicians and nurses have good working relationships	A lot of teamwork between nurses and physicians	Collaboration (joint practice) between nurses and physicians
Foundational Thinking																																					
	Executes the Vision													x											x								x				
	Demonstrates unit level evidence-based decision making													x			x					x			x						x						
	Develops and expresses self-awareness																							x	x			x									
Personal Journey Disciplines																																					
	Seeks direct feedback and adjusts accordingly										x														x		x				x						
	Applies new knowledge at work																x														x						
	Learns from setback and failures as well as successes													x											x		x	x			x						
	Sets initial personal, professional, and career goals													x											x												
	Identifies positive role models and seeks advice																														x						
Systems Thinking																																					
	Understands unit level processes and the inter-relatedness of inter-disciplinary roles, functions, and responsibilities										x						x					x			x	x											
	Expresses and builds concerns for unit's success												x	x			x	x				x		x	x		x	x				x					
	Understands unit goals in concert with the Commander's lines of effort												x	x								x			x												
	Responds to divergent inputs and chooses best practices										x														x			x									
Succession Planning																																					
	Self motivated and motivates others										x		x	x				x				x		x	x	x	x	x									
	Develops a succession plan for own position												x											x	x			x									
	Prepares self for next leadership level																																				
	Identifies and develops talent in staff										x		x					x						x	x	x	x	x									
Change Management																																					
	Identifies gaps in unit processes										x														x							x					
	Utilize evidence based theoretical framework to initiate unit change																x					x			x						x	x					
	Adapts to changes and contingencies in transforming environments																																				
	Suggests and is receptive to innovations										x														x						x						

Sources: Created by author. Adapted from Army Nurse Corps, *Army Nurse Corps campaign plan*, http://armynursecorps.amedd.army.mil/campaign/campaignplan onwebpagemarch09.pdf (accessed 24 August 2011); Eileen T. Lake, Development of the practice environmental scare of the Nursing Work Index, *Research in Nursing Health* 25, no. 3 (2002): 176-88.

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